Exhibit A

The GUARDIAN Life Insurance Company of America
A Mutual Life Insurance Company
7 Hanover Square, New York, New York 10004

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00256357-DC

(To be attached to and made a part of the Policy)

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00256357-DC is hereby amended effective April 1, 2006 as follows:

Your Employer Rider is hereby declared null and void and replaced with the revised corresponding Employer Rider attached hereto.

The Guardian Life Insurance Company of America
A Mutual Life Insurance Company
7 Hanover Square, New York, New York 10004

Incorporated 1860 by the Laws of the State of New York

EMPLOYER RIDER

Group Policy Number: G-00256357-DC

Policyholder: Trustees of the Construction Industry Insurance Trust Fund

Participating Employer: V.R.H. CONSTRUCTION CORP.

Rider Effective Date: February 1, 1990

It is hereby agreed that the provisions which follow are added to the group policy, for the Participating Employer named above:

(A) Definitions:

(1) **"We", "us", "our"** and **"Guardian"** mean The Guardian Life Insurance Company of America.

(2) **"You"** and **"your"** mean the Participating Employer named above.

(3) **"Plan"** means the Guardian plan of group insurance you purchased.

(4) **"Policy Anniversary"** means February 1st , of each year, starting in 2000.

(B) Premium Payments: The first premium payment for this plan is due on the Rider Effective Date. Further payments are due on the the 1st of each month day of each month thereafter, as long as this plan stays in effect.

There is a 31 day grace period for all payments except the first. We must receive all payments within 31 days of the applicable premium due date. If we don't, this plan will automatically end at the end of the grace period. And you will owe us all unpaid premiums for the period this plan was in force.

(C-1) Term of Rider - Renewal Privilege: This rider is issued for an initial term which starts on the Rider Effective Date and ends on the day before the first policy anniversary date.

You can renew this rider for further one year terms on each policy anniversary, subject to all of the terms of the group policy and this rider. But we have the right to cancel this rider, or any coverage hereunder, on any policy anniversary date or premium due date, if, on that date, either:

(1) less than ten employees are insured under this Rider; or

(2) less than 75% of those employees who are eligible for insurance under this rider are insured.

If this rider also provides dependents coverage, we can cancel that coverage on any policy anniversary date or premium due date, if, on that date, less than 75% of those employees eligible for such dependents coverage are insured.

And, if we give you 31 days advance written notice, we may, as of the first day of any policy month, change the premium rates we charge for this plan.

You can cancel this plan at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And you will owe us all unpaid premiums for the period this plan is in force.

(C-2) Incontestability: The group policy shall be incontestable after two years from its date of issue except for non-payment of premiums. With respect to a Participating Employer, this rider shall be incontestable based on statements made in the application after two years from the Rider Effective Date.

A covered person's insurance under this plan shall be incontestable after two years from his or her effective date, except for violation by the covered person of the conditions, if any, of this plan relative to military or naval service.

If this plan replaces the group plan of another insurer, we may rescind the Participating Employer's plan based on misrepresentations made in an employee's or the Participating Employer's signed application for up to two years from the Rider Effective Date.

(D) Associated Companies: An associated company is a firm affiliated with you through common ownership or control.

If you ask us in writing to include such a firm under this plan, and we give you our written approval, we'll treat employees of that firm like your employees. Our written approval will include the starting date of the firm's coverage by this plan. But each eligible employee of that firm must still meet all of the terms and conditions of this plan before he'll be insured.

You must notify us in writing when a firm stops being associated with you. On the date a firm stops being an associated company, this plan will end for all of that firm's employees, except those employed by you or another covered associated company as active full-time eligible employees on such date.

SCHEDULE OF INSURANCE AND PREMIUM RATES

This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

Class Description

Class 0001 ALL ELIGIBLE EMPLOYEES EXCLUDING UNION LABOR EMPLOYEES

Option Packages Available

Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

Members of Class 0001 may choose from benefit option packages A.

Summary of Option Packages

The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

Option A Employee Basic Term Life Insurance in the amount of $25,000.00.

Employee Accidental Death and Dismemberment Insurance in the amount of $25,000.00

Long Term Disability Income Insurance in the amount of 60% of an employee's insured earnings, rounded to the nearest dollar, if not already a multiple thereof, to a maximum monthly benefit of $5,000.00.

Major Medical utilizing a Preferred Provider Organization network with no deductible for in-network charges, a benefit year deductible of $200.00 for out-of-network charges for each covered person, a $5.00 encounter fee required for each doctor's office visit, and a higher co-payment required for out-of-network charges.

Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services. A lower level of benefits is paid if the covered person does not use the services of a preferred provider.

Employee and Dependent Prescription Drug Expense Insurance with co-pays for each prescription or refill of $40.00 for mail order brand name drugs, $20.00 for mail order generic drugs, $20.00 for non-mail order brand name drugs, and $10.00 for non-mail order generic drugs.

Option A

Basic Term Life Insurance Amount

The Insurance Amount is $25,000.00

Option A

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

Option A

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which the employee is eligible if an employee's insurance under this plan starts both: (a) after this plan's effective date; and (b) after he or she reaches age 70.

If an employee provides us with proof of insurability, and we approve it in writing, the amount of his or her insurance will be 50% of the amount which otherwise applies to his or her classification and/or option. But in no event will this reduced amount be less than $1,000.00.

If we do not approve the employee's proof, his or her insurance amount will be $1,000.00.

Option A — Schedule of Benefits

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

Option A

Basic AD&D Insurance Amount

Insurance Amount $25,000.00

Option A

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

Option A

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which the employee is eligible if an employee's insurance under this plan starts both: (a) after this plan's effective date; and (b) after he or she reaches age 70.

If an employee provides us with proof of insurability, and we approve it in writing, the amount of his or her insurance will be 50% of the amount which otherwise applies to his or her classification and/or option. But in no event will this reduced amount be less than $1,000.00.

If we do not approve the employee's proof, his or her insurance amount will be $1,000.00.

Option A — Schedule of Benefits

Employee Long Term Disability Income Insurance

Option A

Own Occupation Period

The first 24 months of benefit payments from this plan.

Option A

Elimination Period

For disability due to injury . . . . . 90 days

For disability due to sickness . . . . . 90 days

Maximum Payment Period

See the following table:

Age when disability starts	Maximum payment period
Under age 60	To age 65

Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 *or* older	1.00 year

Option A

Benefit Percent 60%

Option A

Maximum Monthly Benefit $5,000.00

Option A

Earnings Definition *Insured earnings* means a covered person's rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the *plan sponsor.* If a covered person is paid hourly, we calculate monthly earnings based on actual hours worked or billed in the two months before the start of his or her *disability.* We do not include pay for hours worked or billed over 40 per week. *Insured earnings* includes the covered person's contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

Option A

Redetermination This plan redetermines *insured earnings* for each covered person on the date a change in a covered person's *insured earnings* occurs. As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan*. However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability*.

Option A — Schedule of Benefits

Employee and Dependent Major Medical Expense

Option A

Benefit Year Cash Deductible

For covered charges from a PPO provider . . . . . None

For covered charges from a non-PPO provider $200.00

Option A

Family Deductible Cap

For the PPO deductible . . . . . None

For the Non-PPO deductible $400.00

Option A

Encounter Fee

For each visit to a PPO doctor's office . . . . . $ 5.00

(See the definition of "Encounter Fee" for a complete explanation.)

Option A

Co-Payments

Co-payments are the percentage of a covered charge that must be paid by a covered person. This plan's co-payments, shown below, do not include penalties incurred under this plan's Utilization Review provisions, or any other non-covered expense.

The co-payments for this plan are as follows:

For most covered charges -

Before the co-payment cap is met -

From a hospital which is a preferred provider . . . . . No co-payment

From another hospital 20%

From a doctor who is a preferred provider . . . . . No co-payment

From another doctor 20%

For other types of charges 20%

After the co-payment cap is met . . . . . No co-payment

Note: There may be different payment rates for some types of charges. Read all provisions of this plan carefully.

Option A

Co-Payment Cap

Limit on co-payments per covered person each benefit year $1,000.00

Limit on co-payments per covered family each benefit year $2,000.00

Option A

Out-of-Pocket Cap

Per covered person each benefit year:

For covered expenses from a Preferred Provider $1,000.00

For covered expenses from a Non-Preferred Provider $1,200.00

Per covered family each benefit year;

For covered expenses from a Preferred Provider $2,000.00

For covered expenses from a Non-Preferred Provider $2,400.00

GP-1-SI P130.5174

Option A

Daily Room and Board Limits

During a Period of Hospital Confinement:

For semi-private room and board accommodations, we cover charges up to the hospital's actual daily room and board charge.

For private room and board accommodations, we cover charges up to the hospital's average daily semi-private room and board charge, or if the hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For special care units, we cover charges up to the hospital's actual daily room and board charge.

For a Confinement In an Extended Care Center or Rehabilitation Center:

We cover the lesser of: (a) the center's actual daily room and board charge; or (b) 50% of the covered daily room and board charge made by the hospital during the covered person's preceding hospital confinement, for semi-private accommodations.

Option A

Payment Limits

For each sickness or injury we pay up to the payment limit shown below:

Charges for in-patient confinement in an extended care or rehabilitation center, per benefit year . . . . . 100 days

Charges for home health care, per benefit year . . . . . 100 visits

Charges for treatment of disease or deformity of the feet, per benefit year $2,500.00

Charges for manipulation, or adjustment of the spine, per benefit year . . . . . 30 visits

All Other Charges:

Lifetime payment limit for each sickness or injury not listed above . . . . . unlimited

GP-1-SI P130.4349

Option A — Schedule of Benefits

Employee and Dependent Dental Expense

Option A

Cash Deductible

PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

Group 1 Services	None
Group 2 and 3 Services	$50.00 for each covered person

Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

Group 1, 2 and 3 Services	$50.00 for each covered person

Option A

Payment Rates

Payment Rate for Services Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	90%
Group 3 Services	60%
Group 4 Services	50%

Payment Rate for Services **Not** Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	80%
Group 3 Services	50%
Group 4 Services	50%

Option A

Payment Limits

Benefit Year Payment Limit for Non-Orthodontic Services - up to	$ 1,000.00
Orthodontic Lifetime Maximum - up to	$ 1,000.00

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

Option A — Schedule of Benefits

Employee and Dependent Prescription Drug Expense Insurance

Option A

Co-Pays Per Prescription Or Refill

For *Brand Name Drugs* received from a *Mail Order Pharmacy*	$40.00
For *Generic Drugs* received from a *Mail Order Pharmacy*	$20.00
For *Brand Name Drugs* not received from a *Mail Order Pharmacy*	$20.00
For *Generic Drugs* not received from a *Mail Order Pharmacy*	$10.00

Option A

Changes in Insurance Amounts

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) *or*
- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

Schedule of Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

Option A — Premium Rates

Employee Basic Term Life Insurance

Option A Class 0001

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Employee
$ .36

Option A — Premium Rates

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

Option A Class 0001

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Employee
$ .035

Option A — Premium Rates

Employee Long Term Disability Income Insurance

Option A Class 0001

The following set of rates represents the rate per $100.00 of monthly covered payroll volume.

"Age" means the employee's attained age in years as of this plan's anniversary date.

Age		
From	Through	Rate per Employee
15	24	$ .14
25	29	$ .16
30	34	$ .20
35	39	$ .28
40	44	$ .44
45	49	$ .75
50	54	$ 1.07
55	59	$ 1.22
60	99	$ .86

Option A — Premium Rates

Major Medical Expense Insurance

Option A Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child with no Insured Spouse	per Employee and Insured Family
$ 479.42	$ 933.97	$ 867.35	$ 1,322.00

Option A — Premium Rates

Dental Expense Insurance

Option A Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child with no Insured Spouse	per Employee and Insured Family
$ 38.06	$ 78.92	$ 72.36	$ 113.24

Option A — Premium Rates

Prescription Drug Expense Insurance

Option A Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child with no Insured Spouse	per Employee and Insured Family
$ 137.72	$ 252.53	$ 238.17	$ 352.99

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

Option A

A specimen copy of the master group policy provisions which apply to the plan of insurance for the participating employer named on the first page of this rider, is attached hereto and incorporated herein. The originals of such provisions are part of the master group policy which was delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

If this plan of insurance includes major medical, dental or prescription drug coverages, these coverages provide benefits for employees and dependents.

Option A

This rider shall form a part of the group policy. You, the policyholder and the Guardian are all subject to all of the terms and conditions contained in the group policy and this rider.

Dated at Bethlehem, PA This 10th Day of May , 2006

The Guardian Life Insurance Company of America

Second Vice President & Actuary, Group Insurance

Option A

Trustees. The term "trustees" shall mean the Citizens Savings Bank and Citizens Trust Company.

Participating Employers - Eligible Employer. An Eligible Employer may become a Participating Employer by filing, through the Trustees, with the Home Office of the Insurance Company an agreement executed by the employer adopting the terms of the Trust Agreement and by receiving the Insurance Company's approval, in writing, of its inclusion as a Participating Employer. The date the employer becomes a Participating Employer shall be stated in the Employer Rider pertaining to such Employer. "Employer Rider" as used any place in this Policy shall mean each separate rider or riders, attached to and forming part of this Policy, identifying and specifically applying to each employer who is a Participating Employer under this Policy and which contains details of the plan of insurance pertaining to the employees of each such Participating Employer.

"Eligible Employer" as used above shall mean any employer engaged in the industry covered under this Policy.

Participation Date. The date as of which an Employer becomes a Participating Employer is referred to herein as the Participation Date with respect to such Employer and its Employees.

Employees Eligible. Those employees identified in the Employee Riders are eligible for insurance under this Policy for the insurance coverages specified therein.

Termination of Employee Coverage. An Employee's insurance on behalf of himself under this Policy shall automatically terminate:

(1) If his employment terminates.

(2) If he ceases to be a member of the classes of employees eligible for the insurance.

(3) If this Policy terminates.

(4) If this Policy is discontinued with respect to the Employees of his Participating Employer.

Termination of employment shall be deemed to occur when the Employee ceases active service on a full-time basis with his Participating Employer, except to the extent this requirement is modified in the Employer Rider pertaining to each Participating Employer.

Schedule of Insurance and Premium Rates:

Schedule. This Group Policy, together with any amendments thereto, contains all the insurance coverages which may be provided by the Employer Rider. The insurance benefits, and the amount thereof, for which the employee is eligible under this Policy on behalf of himself, and on behalf of his dependents if they are covered under this Policy, shall be in accordance with the provisions of the Employer Rider pertaining to each Participating Employer. The classification of each individual Employee shall be determined by the Policyholder from time to time without discrimination among persons in like circumstance, and such determination shall be final and conclusive.

TGP-1-MET P140.9047

Option A

Premiums: Premiums under this Policy are due and payable, as specified on the first page of this Policy, by the Policyholder at an office of the Insurance Company or to an authorized representative. By mutual agreement between the Policyholder and the Insurance Company the interval of payment may be changed, with appropriate adjustment to provide for payment annually, semi-annually, quarterly, or monthly.

The premium due under this Policy on each premium due date shall be the sum of the premium charges for the insurance coverages provided for Participating Employers under this Policy and shall be based upon the rates set forth in the Employer Riders, provided that (a) on the first anniversary of any such Rider and on the

first day of any month thereafter, and (b) on any date the extent of coverage for a Participating Employer under any such Rider is changed by amendment to this Policy, or to such Rider, the Insurance Company may, by advance written notice to the Policyholder, change the rates at which further premiums due for the Insurance provided under such Rider shall be computed. Such change shall apply to premiums due on and after the effective date of the change stated in such notice. The Insurance Company, however, shall not have the right to change the rates under (a) above more than once during any twelve consecutive months, with respect to an Employer Rider.

Adjustment of Premiums Payable Other Than Monthly or Quarterly: If under the foregoing provisions, a premium rate is changed, (or if under the provision "Computation of Group Life Insurance Premiums", an average premium rate is changed) after an annual or semi-annual premium became payable with respect to coverage on or after the date of such change, such premium shall be adjusted by a proportionate increase or decrease for such unexpired period for which such premium became payable. If the adjustment results in a decrease in such premium which became payable the amount of the decrease for such unexpired period shall be payable to the Policyholder by the Insurance Company. If the adjustment results in an increase in such premium which became payable the amount of the increase for such unexpired period shall be considered a premium due on the date of such change, and the Policy provisions concerning grace period shall apply thereto.

Liability of Trustees to Pay Premiums: The Trustees (the Policyholder hereunder) shall be exempt from personal liability with respect to the premiums required by this Policy to be paid by them, but shall be liable for such premiums only in their fiduciary capacity.

Grace in Payment of Premiums - Termination of Policy: A grace period of thirty-one days, without interest charge, will be allowed the Policyholder for the payment of the premium due under this Policy on any due date except the first. If any premium with respect to the Employees of any Participating Employer is not paid before the expiration of the grace period, this Policy shall automatically terminate with respect to all Employees of such Participating Employer at the expiration of the grace period, except that if the Policyholder shall have given the Insurance Company written notice in advance of an earlier date of termination during the grace period, this Policy shall terminate with respect to all Employees of such Participating Employer as of such earlier date. The Policyholder shall be liable to the Insurance Company for all unpaid premiums with respect to the Employees of a Participating Employer for the period (including a pro-rata premium for the grace period or fraction thereof) during which this Policy was in force with respect to such Employees.

This Policy shall terminate immediately upon termination of an insurance coverage under this Policy if, as the result of the termination of such coverage, no benefits remain in effect under this Policy.

Term of Policy and Employer Riders - Renewal Privilege: This Policy is issued for a term of one (1) year from its effective date. All Policy years and Policy months shall be calculated from the effective date. All periods of insurance under the Employer Riders shall begin and end at 12:01 A.M. Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each successive anniversary of its effective date; provided, however, that the Insurance Company has the right to: (A) decline to renew this Policy on any anniversary, and (B) to decline to renew a particular insurance coverage on the first anniversary, or on any premium due date thereafter, if with regard to (A) the number of Employees insured under this Policy, or with regard to (B) the number of Employees insured for such Coverage, shall be less than twenty-five. If, in accordance with the preceding paragraph, the Policy is not renewed, all Employer Riders shall thereupon terminate as of the date the Policy terminates. Subject to the foregoing, the renewability of the insurance provided under an Employer Rider shall be in accordance with the provisions of such Rider.

Renewal is conditioned upon payment of the premium then due, computed as provided in the Section entitled "Premiums".

Option A

The Contract: The Policy and any riders or amendments hereto, and the Application of the Participating Employer, a copy of which is attached hereto or endorsed hereon and made a part hereof, constitute the entire contract between the parties.

The Policy may be amended at any time, without the consent of the Employees insured hereunder or any other person having a beneficial interest therein, upon written request made by the Participating Employer and agreed to by the Insurance Company, but any such amendment shall be without prejudice to any claims arising prior to the date of the change. No agent is authorized to alter or amend this Policy, to waive any conditions or restrictions contained herein, to extend the time for paying a premium, or to bind the Insurance Company by making any promise or representation or by giving or receiving any information. No change in this Policy shall be valid unless evidenced by an endorsement or rider hereon signed by the President, a Vice President, a Secretary, the Actuary, and Associate Actuary, an Assistant Secretary or an Assistant Actuary of the Insurance Company, or by an amendment hereto signed by the Policyholder and by one of the aforesaid officers of the Insurance Company.

Wherever in this Policy a personal pronoun in the masculine gender is used or appears, it shall be taken to include the feminine also, unless the context clearly indicates the contrary.

Incontestability: This Policy shall be incontestable after two years from its date of issue except for non-payment of premiums. With respect to a Participating Employer, the policy shall be incontestable based on statements made in the application after two years from the Employer Rider Effective Date.

With respect to the insurance on an Employee and/or his eligible dependents, their insurance shall be incontestable after two years from his effective date, except for violation by the Employee of the conditions, if any, of this Policy relative to military or naval service.

Clerical Error - Misstatements: Neither clerical error by the Policyholder, a Participating Employer, or by the Insurance Company in keeping any records pertaining to insurance under this Policy, nor delays in making entries thereon, shall invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment of premiums shall be made.

If the age of an employee, or any other relevant facts, be found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums shall be made, and if such misstatement affects the existence on the amount of insurance, the true facts shall be used in determining whether insurance is in force under the terms of this Policy and in what amount.

Statements: No statements shall avoid the insurance under this Policy, or be used in defense of a claim hereunder unless in the case of the Participating Employer, it is contained in the Application for this Policy, signed by him and in the case of an Employee, it is contained in a written request or application signed by him and a copy of which has been furnished to him or to his beneficiary.

All statements shall be deemed representations and not warranties.

Employee's Certificate: The Insurance Company will issue to the Participating Employer, for delivery to each Employee insured hereunder, a copy of his application and certificate booklet which shall state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable, and in case of group life insurance, the provisions of the section "Conversion Privilege." Any such certificate shall not constitute a part of this Policy and shall in no way modify any of the terms and conditions set forth in this Policy.

In the event this Policy is amended by changes which affect the description of the essential features of the insurance contained in an Employee's Certificate, a rider or revised certificate reflecting such changes will be issued to the Policyholder for delivery to the Employee.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

Dividends: The portion, if any, of the divisible surplus of the Insurance Company allocable to this Policy at each Policy anniversary shall be determined annually by the Board of Directors of the Insurance Company and shall be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy shall be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

If the dividends under this Policy should be in excess of the Policyholder's cost of insurance, such excess shall be applied for the sole benefit of the Employees.

Payment of any dividend to the Policyholder shall completely discharge the liability of the Insurance Company with respect to the dividend so paid.

Assignment: The right of the Insured Employee to assign any interest under this policy shall be governed as follows:

(1) With respect to Group Term Life Insurance (Including Employee Basic Term Life Insurance and Employee Supplemental Term Life Insurance if provided under the Policy), the Insured Employee may, subject to the following conditions, assign all rights or interest of every kind which he now has, or hereafter may acquire, in such insurance, including, but not limited to, those stated under the applicable provisions in this Policy entitled "BENEFICIARY", "CONVERSION PRIVILEGE" and "OPTIONAL MODES OF SETTLEMENT", provided (a) such assignment be irrevocable and absolute in form, for no value, with the Insured Employee retaining no further interest in such insurance; and (b) the assignment be made to only ONE of the following: the spouse, child or grandchild, parent or grandparent, brother or sister of the Insured Employee, or the trustee of a trust established for the benefit of one or more of these.

(2) With respect to Accident and Health Insurance, neither the Insured Employee's certificate nor the right to insurance benefits hereunder is assignable, except that the benefits, if any, payable for hospital, surgical or medical expense may be assigned to the institution or person providing the service on account of which such benefits become payable.

The Insurance Company shall not be charged with notice of any assignment of interest under this Policy until the original assignment has been accepted and if filed with it at its Home Office. However, the Insurance Company assumes no responsibility for the validity or effect of any such assignment and its position with respect thereto is not altered by filing or recording the same, save as to notice thereof.

Records - Information to be Furnished: The Policyholder shall keep a record of Employees insured, containing, for each Employee, the essential particulars of the insurance. The Policyholder shall, as prescribed by the Insurance Company, periodically forward to the Insurance Company, on the Insurance Company's forms, such information concerning the Employees eligible for insurance under this Policy as may reasonably be considered to have a bearing on the administration of the insurance under this Policy and on the determination of premium rates, and any other information which the Insurance Company may reasonably require with regard to any matters pertaining to this Policy. Any records of the Policyholder, or of the Participating Employers, as may have a bearing on the insurance under this Policy shall be open for inspection by the Insurance Company at any reasonable time.

Claims of Creditors: Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under this Policy shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Employees or their beneficiaries.

Assignment by Trustees or Participating Employers: Assignment or transfer of the interest of the Policyholder or of any Participating Employer under this Policy shall not bind the Insurance Company without its written consent thereto.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00256357-DC

issued by

The Guardian Life Insurance Company of America

to

Trustees of the Construction Industry Insurance Trust Fund
with respect to
V.R.H. CONSTRUCTION CORP.

As of February 1, 1990, this rider amends this Policy as follows:

(1) The following provisions of this Policy are hereby deleted and replaced by the revised corresponding provisions set forth below.

Premiums

Premiums due under this Policy must be paid by the Participating Employer at an office of The Guardian or to a representative that we have authorized. The premiums must be paid as specified in the Employer Rider, unless by agreement between the Participating Employer and The Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi-annually, quarterly or monthly.

The premium due under this Policy on each premium due date will be the sum of the premium charges for the insurance coverages provided under the Employer Rider. The premium charges are based upon the rates set forth in this Policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates:

- on the first day of any policy month;
- on any date the extent or terms of coverage for a participating Employer are changed by amendment of this Policy, or of the Employer Rider;
- on any date our obligation under this Policy with respect to a participating Employer is changed because of statutory or other regulatory requirements; or
- on any date our obligation under an Employer Rider is changed because of a change in the benefits: (a) with which the benefits provided by an Employer Rider are coordinated; or (b) which are supplemented by the benefits provided by an employer rider.

We must give the Participating Employer 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the Participating Employer by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period provisions will apply to any such premium due.

Grace in Payment of Premiums - Termination of Policy

A grace period of 31 days, without interest charge, will be allowed the Participating Employer for each premium payment except the first. If any premium with respect to the employees of a Participating Employer is not paid before the end of the grace period, such employees' coverage under this policy automatically ends at the end of the grace period. However, if the Participating Employer gives us 31 days written notice in advance of an earlier termination date during the grace period, such employees' coverage under this Policy ends as of such earlier date.

If the coverage of the employees of a Participating Employer ends during or at the end of the grace period, the Participating Employer will still owe us premium for all the time coverage was in force with respect to such employees during the grace period.

This Policy ends immediately on any date when an insurance coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

GP-1-A-GP-90-1 P150.0004

Option A

Incontestability

This Policy is incontestable after two years from its date of issue, except for non-payment of premiums.

A Participating Employer's insurance under this Policy shall be incontestable after two years from his Rider Effective Date, except for nonpayment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this Policy shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If the Participating Employer's group plan replaces the group plan he had with another insurer, we may rescind his plan based on misrepresentations made by the Participating Employer or a covered person in a signed application for up to two years from the Rider Effective Date.

GP-1-A-GP-90-2 P150.0005

Option A

The Contract

The entire contract between the Guardian and the Participating Employer consists of this Policy and any amendments thereto which pertain to his plan of insurance, including the Participating Employer's Employer Rider, and the Participating Employer's application, a copy of which is attached hereto or endorsed hereon.

We can amend this Policy or an Employer Rider at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this Policy or an Employer Rider:

- upon written request made by the Participating Employer and agreed to by The Guardian;
- on any date our obligation under this Policy with respect to a Participating Employer is changed because of statutory or other regulatory requirements; or
- on any date our obligation under an Employer Rider is changed because of a change in the benefits: (a) with which the benefits provided by an Employer Rider are coordinated; or (b) which are supplemented by the benefits provided by an Employer Rider.

If we amend the Policy or an Employer Rider, except upon request made by the Participating Employer, we must give the Participating Employer written notice of such amendment. And the amendment must be signed by the Participating Employer and us.

This a specimen copy of Master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Any amendments to this Policy or an Employer Rider will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, Policy or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or Policy, or any requirements of The Guardian; (c) bind us by any statement or promise relating to the insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

All personal pronouns in the masculine gender used in this Policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

Clerical Error - Misstatements

Neither clerical error by the Policyholder, a Participating Employer or The Guardian in keeping any records pertaining to insurance under this Policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Participating Employer will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, subject to this policy's "Incontestability" provision, the true facts will be used in determining whether insurance is in force under the terms of this Policy and the Employer Rider, and in what amount.

Statements

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless: (a) in the case of the Participating Employer, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument which is signed by him; a copy of which is furnished to him or his beneficiary.

All statements will be deemed representations and not warranties.

Option A

Assignment

An employee's right to assign any interest under this Policy is governed as follows:

- With respect to any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages provided by this Policy), the employee may, subject to the following conditions, assign all rights or interest in such insurance which he now has, or may later acquire.

  The assignment of an employee's death benefits is irrevocable and absolute in form, for no value. The employee retains no further interest in such insurance.

  The assignment may be made only to one of the following: The employee's spouse, child, grandchild, parent, grandparent, brother or sister. It may also be made to the trustee of a trust established for the benefit of one or more of these people.

  We will not be charged with notice of any assignment of any interest under this Policy until the original assignment has been accepted and filed with us at our Home Office. And we assume no responsibility as to the validity or effect of any such assignment.

- With respect to accident and health insurance, neither the employee's certificate nor his right to insurance benefits under this Policy are assignable. The employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such direction at our option. But, such a direction is not considered an assignment of benefits and the employee may not assign his right to take legal action under this Policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Option A

Records - Information To Be Furnished

The Participating Employer must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The Participating Employer must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this Policy, as set forth in the Employer Rider, as may reasonably be considered to have a bearing on the administration of the insurance under this Policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The Participating Employer's payroll and other such records which have a bearing on the insurance must be furnished to us for inspection at our request at any reasonable time.

(2) The following provisions are hereby added to this Policy:

Accident and Health Claims Provisions

An employee's right to make a claim under this Policy for any accident and health benefits provided under an Employer Rider, is governed as follows:

Notice: An employee must send us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include the employee's name and plan number. If the claim is being made for one of the employee's covered dependents, his name should also be noted.

Proof of Loss: We'll furnish the employee with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The employee must detail the nature and extent of the loss for which the claim is being made.

If an Employer Rider provides weekly loss of time benefits, the employee must send us written proof of loss within 90 days of the end of each period for which we're liable. If an Employer Rider provides long term disability income replacement benefits, the employee must send us written proof of loss within 90 days of the date we request it. For any other loss, the employee must send us written proof of loss within 90 days of the loss.

Late Notice of Proof: We won't void or reduce an employee's claim if he can't send us notice of proof of loss within the required time. But he must send us notice and proof as soon as reasonably possible.

Payment of Benefits: If an Employer Rider provides benefits for loss of income, we'll pay them once every 30 days for as long as we're liable, provided the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee is entitled under an Employer Rider as soon as we receive written proof of loss.

We pay all accident and health benefits to the employee, if he is living. If he is not living, we have the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) the employee's estate; (b) the employee's spouse; (c) the employee's parents; (d) the employee's

children; (e) the employee's brothers and sisters; and (f) any unpaid provider of health care services. If an Employer Rider provides benefits for dismemberment, see "Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When an employee files proof of loss, he may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. But we can't tell the employee that a particular provider provide such care. And the employee may not assign his right to take legal action under this Policy to such provider.

Limitations of Actions: An employee can't bring a legal action against this Policy until 60 days from the date he files proof of loss. And he can't bring legal action against this Policy after three years from the date he files proof of loss.

Workers' Compensation: The accident and health benefits provided by this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

GP-1-A-GP-90-5 P150.0008

Option A

Examination and Autopsy

We have the right to have a doctor of our choice examine the person for whom a claim is being made under this Policy as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

(3) As used in this rider:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, or weekly loss-of-time insurance provided under an Employer Rider.

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Policy" means the master group policy of insurance.

(4) This Policy's provision entitled "Liability of Trustees to Pay Premiums" is hereby deleted.

This rider is a part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Dated at _____ This _____ Day of _____ , ____

Trustees of the Construction Industry Insurance Trust Fund
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

Second Vice President & Actuary, Group Insurance

GP-1-A-GP-90-6 P150.0009

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

POLICY RIDER

Your plan of major medical expense and/or prescription drug expense insurance is amended so that in addition to any other provision of this policy which deals with cancellation or nonrenewal, we have the right to cancel your major medical expense and/or prescription drug expense insurance on any policy anniversary, if on such date:

- subject to 180 days advance notice, we leave the medical insurance market;
- you have committed fraud or misrepresentation; or
- if your medical plan utilizes a provider network, no covered persons live or work in the network service area.

The Guardian Life Insurance Company of America

Second Vice President & Actuary, Group Insurance

GP-1-A-YO-98 P150.0084

This is a specimen copy of a master group policy providing insurance. The original of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

COORDINATION BETWEEN CONTINUATION SECTIONS

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations:

(a) start at the same time;

(b) run concurrently; and

(c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections:

(a) will not be entitled to duplicate benefits; and

(b) will not be subject to the premium requirements of more than one section at the same time.

GP-1-R-COC-87 P240.0038

Option A

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if:

(a) the employer is subject to the "Federal Continuation Rights" section, and therefore;

(b) the section applies to the employee.

GP-1-R-NCC-87 P240.0058

Option A

Federal Continuation Rights

Important Notice: This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active, covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Conversion: Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If an Employee's Group Health Benefits End: If an employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if he or she was not terminated due to gross misconduct.

The continuation: (a) may cover the employee or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees: If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the employee's termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give you written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify you within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by you during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

GP-1-R-COBRA-96-1 P235.0131

Option A

If an Employee Dies While Insured: If an employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

GP-1-R-COBRA-96-2 P235.0096

Option A

If an Employee's Marriage Ends: If an employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility: If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than the employee's coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations: If a dependent elects to continue his or her group health benefits due to the employee's termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule: If the employee becomes entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after the employee's later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from the employee's termination of employment or reduction of work hours; or (b) 36 months from the date of the employee's earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify you, in writing, of: (a) the legal divorce or legal separation of the employee from his or her spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to you by a qualified continuee within 60 days of the latest of: (a) the date on which the event occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to you and this plan's procedures for providing such notice.

Notice of a disability determination must be given to you by a qualified continuee within 60 days of the latest of (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to you and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

Such notice must be given to you within 60 days of either of these events.

GP-1-R-COBRA-96-3 P235.0126

Option A

Your Responsibilities: You must notify the qualified continuee, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to the employee's death or the employee's termination of employment or reduction of work hours; (b) the date a qualified continuee notifies you, in writing, of the employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured dependent child; or (c) the date you declare bankruptcy under Title 11 of the United States Code.

If you determine that an individual is not eligible for continued group health benefits under this plan, you must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, you must notify the qualified continuee as soon as practical following determinatin that the continued group health benefits shall terminate.

Your Liability: You will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) you fail to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) you fail to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation: To continue his or her group health benefits, the qualified continuee must give you written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from you as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to you, by the qualified continuee, in advance, at the times and in the manner specified by you. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by you. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by you.

If the qualified continuee fails to give you notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless you notify the qualified continuee of the amount of the deficiency and grant an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to you.

When Continuation Ends: A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon the employee's death, the employee's legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date you cease to provide any group health plan to any employee;

(5) the end of the period for which the last premium payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

Option A

Any person whose continued health benefits end as described in (1), (2), (3) or (4) above may elect to convert some of these benefits to an individual insurance policy we normally issue for conversions at the time he or she elects to convert, if conversion is available under this plan.

If conversion is available, the applicant must apply to us in writing and pay the required premium. This must be done within 31 days of the date the applicant's continued group health benefits end. We do not ask for proof of insurability. The converted policy takes effect on the date the applicant's continued group health benefits end. If the applicant is a minor or incompetent, the person who cares for and supports the applicant may apply for him or her.

The converted policy will be renewable and will comply with the laws of the place the applicant lived when he or she applied. But, it will not provide exactly the same benefits the applicant had under the group plan. Write to us for details.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

The premium for the converted policy will be based on: (a) the policy the applicant selects; (b) the risk and rate class, under the group plan, of the people to be covered; and (c) the ages of the people to be covered as of the date the converted policy takes effect.

A covered person may also convert in certain other situations. Read this plan's group health conversion section for details. But, at no time can a person be covered under more than one converted health policy.

GP-1-R-COBRA-96-5 P235.0103

Option A

Uniformed Services Continuation Rights

An employee who enters or returns from military service, may have special rights under this plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If an employee's group health benefits under this plan would otherwise end because he or she enters into active military service, this plan will allow the employee, or his or her dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this plan.

Coverage under this plan may be continued while the employee is in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if the employee fails to return to work in a timely manner after military service ends as provided under USERRA. You must provide the employee with details about this continuation provision including required premium payments.

GP-1-R-COBRA-96-5 P235.0140

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

Important Notice: This section applies to hospital, surgical and medical expense coverages. It also applies to dental and prescription drug coverages. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or for loss of income due to disability. These coverages cannot be continued under this section.

If An Employee Is Totally Disabled: An employee who is totally disabled and whose group health benefits end because his active employment or membership in an eligible class ends due to that disability, can elect to continue his group health benefits. But he must have been insured by this plan for at least three months immediately prior to the date his group health benefits ends. The continuation can cover the employee, and at his option, his then insured dependents.

Under this section, we will consider an employee to be totally disabled if he: (1) is totally unable to work in any suitable occupation due to a sickness or an injury; and (2) is not actually working in any occupation for wage or profit. When we determine if an occupation is suitable, we look at the employee's education, training and experience.

How And When To Continue Coverage: To continue group health benefits, the employee must give the employer written notice that he elects to continue such benefits. And he must pay the first month's premium. This must be done within 31 days of the date his group health benefits would otherwise end.

Subsequent premiums must be paid to the employer monthly, in advance, at the times and in the manner specified by the employer. The monthly premium the employee must pay will be the total rate charged for an active full-time employee, insured under this plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the employer.

We will consider the employee's failure to give notice or to pay any required premium as a waiver of the employee's continuation rights.

If the employer fails, after the timely receipt of the employee's payment, to pay us on behalf of such employee, thereby causing the employee's group health benefits to end; then such employer will be liable for the employee's benefits, to the same extent as, and in place of, us.

When This Continuation Ends: These continued group health benefits end on the first of the following:

(a) the end of the period for which the last payment is made, if the employee stops paying;

(b) the date the covered person becomes eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

(c) the date the group plan ends or is amended to end for the class of employees to which the employee belonged; or

(d) with respect to a dependent, the date he stops being an eligible dependent as defined in this plan.

Option A

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

P264.0017

Option A

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0 P180.0168

Option A

Enrollment Requirement: If an employee must pay all or part of the cost of employee coverage, we won't insure him or her until he or she enrolls and agrees to make the required payments. If he or she does this: (a) more than 31 days after he or she first becomes eligible; or (b) after he or she previously had coverage which ended because he or she failed to make a required payment, we will ask for proof that he or she is insurable. And the employee won't be covered until we approve that proof in writing.

GP-1-EC-90-2.0 P264.0070

Option A

Proof of Insurability Requirements: Part or all of an employee's insurance amounts may be subject to proof that he or she is insurable. The Schedule of Insurance explains if and when we require proof. An employee won't be covered for any amount that requires such proof until he or she gives the proof to us and we approve that proof in writing.

An employee whose active full-time service ends before he or she meets any proof of insurability requirements that apply to him or her will still have to meet those requirements if he or she is later re-employed by you or an associated company.

GP-1-EC-90-3.0 P264.0066

Option A

The Waiting Period: Employees in an eligible class are eligible for life and dismemberment insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0 P264.0020

Option A

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0 P180.0328

Option A for Class 0001

When Employee Coverage Starts

An employee must be actively at work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her. If an employee is not actively at work on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he or she was actively at work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

Whether an employee must pay all or part of the cost of employee coverage, he or she must elect to enroll and agree to make the required payments within 31 days of his or her eligibility date. If he or she does this on or before the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs his or her enrollment form. However, if he or she elects to enroll and agrees to make the required payments more than 31 days after his or her eligibility date, his or her coverage won't start until he or she sends us proof that he or she is insurable. Once we've approved it, his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

Any part of an employee's coverage which is subject to proof that he or she is insurable won't start unless he or she sends this proof to us, and we approve it in writing. Once we have approved it, that part of his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

GP-1-EC-90-6.0 P264.0083

Option A for Class 0001

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the date an employee's active full-time service ends for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
- the date an employee stops being an eligible employee under this plan.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs.
- the last day of the period for which required payments are made for the employee.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. And an employee may have the right to replace certain group benefits with converted policies. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0 P264.0038

Option A for Class 0001

When Active Service Ends: You may continue an employee's life and dismemberment insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 01 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0 P264.0021

Option A

Definitions

GP-1-EC-90-DEF-1 P180.0155

Option A

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3 P180.0311

Class 0001

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4 P180.0158

Option A

Plan means the Guardian group plan purchased by the employer.

GP-1-EC-90-DEF-6 P180.0975

Option A

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

GP-1-EC-90-DEF-7 P180.0161

Option A

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9 P180.0163

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10 P180.0164

Option A

Employee Basic Group Term Life Insurance

Basic Life Benefit: If an employee dies while insured for this benefit, we will pay his or her beneficiary the amount shown in the schedule.

The Beneficiary: The employee decides who gets this insurance if he or she dies. He or she should have named a beneficiary on his or her enrollment form. The employee can change his or her beneficiary at any time by giving the employer written notice, unless he or she has assigned this insurance. But the change will not take effect until the employer gives the employee written confirmation of the change.

If the employee named more than one person, but did not tell us what their shares should be, they will share equally. If someone named dies before the employee does, his or her share will be divided equally by the beneficiaries still alive, unless the employee has told us otherwise.

If there is no beneficiary when the employee dies, we will pay the insurance to one of the following: (a) his or her estate; (b) his or her spouse; (c) his or her parents; (d) his or her children; or (e) his or her brothers and sisters.

Proof Of Death: Written proof of death should be sent to us as soon as possible. The claimant may be required to complete a claim form which will be provided to him or her.

Payment Of Benefits: Subject to all of the terms of this plan and the conditions shown below, we will pay this insurance within 60 days after we receive acceptable written proof of death and proof of the interest of the claimant.

If a claim or part of a claim requires additional proof, we will notify the claimant in writing of such fact within 45 days after we receive written proof of death and proof of the interest of the claimant. We will pay any uncontested part of the claim within 60 days after we receive acceptable proof. We will pay any claim or part of a claim that requires additional proof within 90 days after we receive any acceptable document or information that provides the additional proof.

Payment of a claim or part of a claim that does not require additional proof will be overdue if not paid within 60 days after we receive acceptable proof. Payment of a claim that requires additional proof will be overdue if not paid within 90 days after we receive the additional acceptable proof. Overdue payments are required to bear a pro-rated annual rate of interest from the date overdue until the date paid. The required annual rate of interest is equal to the average rate of return of the State of New Jersey Cash Management Fund, rounded to the nearest one-half percent.

Assigning This Life Insurance: If the employee assigns this insurance, he or she permanently transfers all of his or her rights under this insurance to the assignee. Only one of the following can be an assignee: (a) the employee's spouse; (b) one of the employee's parents or grandparents; (c) one of the employee's children or grandchildren; (d) one of the employee's brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by the employee; and (b) a signed or certified copy of the written assignment has been received and approved by us.

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this plan before we receive and approve any assignment.

We suggest the employee speak to a lawyer before he or she makes any assignment. If the employee decides he or she wants to assign this insurance, write to us for details.

Payment To A Minor Or Incompetent: If the employee's beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports the beneficiary.

Payment Of Funeral Or Last Illness Expense: We have the option of paying up to $500.00 of the insurance to any person who incurs expenses for the employee's funeral or last illness.

Settlement Option: If the employee or his or her beneficiary asks us, we will pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

GP-1-R-LB-03-NJ P270.0395

Option A

THE FOLLOWING PROVISION APPLIES TO EMPLOYEE BASIC TERM LIFE INSURANCE:

Option A

Converting This Group Term Life Insurance

If Employment or Eligibility Ends: The employee's group life insurance ends if his employment ends, or if he stops being a member of an eligible class of employees. If either happens, he can convert all or part of his group life insurance to an individual life insurance policy.

If The Group Plan Ends or Group Life Insurance is Dropped: The employee's group life insurance also ends if this group plan ends, or if life insurance is dropped from the group plan for all employees or for his class. If either happens and he's been insured by a Guardian group life plan for at least five years, he can also convert. But, the amount he can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of his insurance under this plan, less any group life benefits he becomes eligible for in the 31 days after this insurance ends.

The Converted Policy: The employee can convert to one of the policies we normally issue. It can't include disability benefits. And, it can't be a term policy.

The premium for the converted policy will be based on: (a) the employee's standard or sub-standard risk and rate class under this plan; and (b) his age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion.

How and When to Convert: To get a converted policy, the employee must apply to us in writing and pay the required premium. He has 31 days after his group life insurance ends to do this. We won't ask for proof that he's insurable.

Death During the Conversion Period: If an employee dies in the 31 days allowed for conversion, we'll pay his beneficiary the amount he could have converted. We'll pay whether or not he applied for conversion.

GP-1-R-LCON-NJ-90 P270.0097

This is a specimen copy of Master Group policy provisions which apply to plans issued in the states of These provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

Extended Life Benefit

Important Notice: This section applies to the employee's basic life benefit. But, it does not apply to his accidental death and dismemberment benefits.

If an Employee is Totally Disabled: If an employee meets our standard for total disability, we'll extend his life insurance under this section. We'll extend it for one year from the date his life insurance under the group plan ended. There will be no cost to you or him.

We'll consider an employee totally disabled if: (a) he is not able to perform any work for wages or profit, due to a sickness or an injury; and (b) he becomes disabled before he reached age 60 and while insured by the group plan.

If an Employee is Permanently Disabled: If an employee is permanently disabled, he may apply for more one year extensions. We'll consider an employee permanently disabled if he's been totally disabled for at least nine continuous months. We'll consider him permanently disabled without the nine month wait, if he's totally disabled because: (a) he's lost two limbs by severance at or above the ankles or wrists; or (b) he's lost total and permanent sight in both eyes.

How and When to Apply: To get this extended benefit past the first year, the employee must send us written medical proof that he's permanently disabled. This must be done before the first one year extension ends. He won't be covered past the first year unless we approve that proof.

Since each extension is only for one year, the employee must send us proof of his continued disability each year. This must be done in the three months before the prior extension ends. He won't be covered past the date the prior extension ends, unless we approve that proof.

Examination by Our Doctor: We can have the employee examined by a doctor of our choice as often as we feel necessary during the first two years we've extended his life benefits. But, after two years, we can't have him examined more than once a year.

When This Extension Ends: This extension will end on the date the employee stops being totally disabled. It will also end if we ask him to be examined by our doctor, and he refuses. And, it will end if he doesn't give us the proof of disability we require.

If this extension ends, and the employee is not insured by the group plan again as an active full-time employee, he can convert as if his employment just ended. Read the section labelled "Converting This Group Term Life Insurance."

If an Employee Dies While Covered By This Extension: If an employee dies while covered by this extension we'll pay his beneficiary the amount he was covered for. This is the amount he had under the group plan on his last day of active work. It is subject to all reductions which would have applied if he had stayed an active employee.

We'll pay as soon as we receive: (a) written proof of the employee's death; **and** (b) medical proof that he was continuously disabled until his death. This must be sent to us within one year of his death.

Until We've Approved an Employee as Permanently Disabled: An employee's life insurance under the group plan may end after he's become totally disabled but before we've approved him as permanently disabled. If this happens, we suggest he reads the section labelled "Converting This Group Term Life Insurance."

Converting does not stop the employee from claiming his rights under this section. But if he converts and we later approve him as permanently disabled, we'll cancel the converted policy. Of course, we'll refund the premiums he paid.

Also, if an employee converts and then dies during the first year of this extension, we'll pay his beneficiary under this section. The beneficiary won't be paid under the converted policy. But, we'll give him the premiums the employee paid for that policy.

A specimen copy of the Group policy provisions which apply to plans of insurance. The provisions of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

COMPUTATION OF GROUP LIFE INSURANCE PREMIUMS

Definitions:

"Plan" means the Guardian group life insurance plan purchased by the employer.

"We", "us", and "our" mean the Guardian Life Insurance Company of America.

"You" and "your" mean the employer who purchased this plan.

How Group Life Rates Are Computed:

The "Table of Individual Rates" shown below will, subject to our rating methods, be used in computing the premium charges for this plan's group life insurance. As stated in this plan's "Premiums" section, we can change that table.

When this plan's group life insurance starts, we'll compute a preliminary monthly rate. We do this by: (1) multiplying the individual rates by the amounts of insurance in force at the respective ages, nearest birthday, of all employees; and (2) dividing the result by the total amount of insurance in force. Using the characteristics of your group, and our rating methods, we'll modify such preliminary rate and compute your final premium rate.

We may also compute your final premium rate by any other method we and you agree upon, which produces approximately the same total premium.

If We Provide Supplemental Term Life Insurance: If we provide Supplemental Term Life Insurance, we'll use the employee's rated age to compute premium rates, if the employee is placed in a substandard class.

If You Pay Monthly Premiums: If you pay monthly premiums, each monthly payment will be equal to the product of the total amount of insurance in force on the premium's due date and the monthly rate in effect for each employee.

If You Pay Annual, Semi-Annual, or Quarterly Premiums: If you pay annual, semi-annual or quarterly premiums, we'll compute the applicable rate by multiplying the monthly rate so obtained by 11.823, 5.956, or 2.985, respectively.

Table of Individual Rates
Group Term Life Insurance
Monthly Premiums Per $1,000.00 of Employee Life Insurance

Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate
15	$ .19	32	$ .28	49	$ .97	66	$ 4.11
16	.20	33	.29	50	1.06	67	4.48
17	.21	34	.30	51	1.16	68	4.89
18	.22	35	.32	52	1.26	69	5.34
19	.23	36	.34	53	1.38	70	5.81
20	.23	37	.36	54	1.51	71	6.32
21	.24	38	.38	55	1.65	72	6.84
22	.24	39	.41	56	1.80	73	7.38
23	.25	40	.45	57	1.97	74	7.95
24	.25	41	.49	58	2.14	75	8.56
25	.25	42	.53	59	2.32	76	9.24
26	.25	43	.58	60	2.51	77	10.00
27	.26	44	.63	61	2.72	78	10.86

Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate	Age Nearest Birthday	Monthly Rate
28	.26	45	.68	62	2.96	79	11.81
29	.26	46	.74	63	3.21	80	12.83
30	.27	47	.81	64	3.48		
31	.27	48	.89	65	3.78		

Upon request we will furnish rates for ages not shown.

Employee Contributions: Employees' required contributions towards the cost of this insurance may not vary solely by sex.

When Rates Can Be Changed: We or you may require appropriate rate changes on each Policy Anniversary after the effective date of this plan, or on any date on which the above table is changed.

GP-1-R-LRMP-86-1 P270.0023

Option A

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

We'll pay the benefits described below if an employee suffers a covered loss due to an accident that occurs while he's insured.

Covered Losses: Covered loss means: (a) loss of life; or (b) single dismemberment; or (c) multiple dismemberment. The loss must be the direct result of an accident which occurs while the employee is insured, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Single dismemberment means: (a) the loss of one hand by severance at or above the wrist; or (b) the loss of one foot by severance at or above the ankle; or (c) the total and permanent loss of sight in one eye. Multiple dismemberment means any two or more single losses due to the same accident.

But, we won't pay benefits for losses we exclude below.

Benefit Amounts: For covered loss of life, we'll pay the full amount shown in the schedule to the same person who gets the employee's group life insurance.

For covered single dismemberment, we'll pay one-half the amount shown in the schedule. For covered multiple dismemberment, we'll pay the full amount shown in the schedule. We'll pay the employee, if living. If not, we'll pay the person who gets the employee's group life insurance.

We'll pay these benefits, in a lump sum, as soon as we receive written proof of the employee's loss. This should be sent to us as soon as possible.

We won't pay more than the full amount shown in the schedule for all losses due to the same accident, except under the Common Carrier provision.

Common Carrier: We'll pay two times the amount which otherwise applies, if the employee's loss is due to an accident which occurs while he's riding in a public conveyance. But, he must be riding as a fare-paying passenger.

Exclusions: We won't pay for any loss caused directly or indirectly by:

(1) intentional self-injury, suicide, or attempted suicide.

(2) disease of any kind, and any treatment of such disease.

(3) infection, except septic infection of and through a visible wound accidentally sustained.

(4) the employee's taking part in a riot or other civil disorder, or in the commission of a felony.

(5) travel on any type of aircraft if the employee is an instructor or crew member, or has any duties at all on that aircraft.

We won't pay for any loss which occurs while the employee is a member of any armed force.

We won't pay for loss of life caused directly or indirectly by the employee's voluntary use of a controlled substance, unless: (1) it was prescribed for him by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

Option A

ELIGIBILITY FOR DISABILITY INCOME REPLACEMENT COVERAGE

P329.0002

Option A

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0 P180.0168

Option A

Enrollment Requirement: If an employee must pay all or part of the cost of employee coverage, we won't insure him or her until he or she enrolls and agrees to make the required payments. If he or she does this: (a) more than 31 days after he or she first becomes eligible; or (b) after he or she previously had coverage which ended because he or she failed to make a required payment, we will ask for proof that he or she is insurable. And the employee won't be covered until we approve that proof in writing.

GP-1-EC-90-2.0 P264.0070

Option A

Proof of Insurability Requirements: Part or all of an employee's insurance amounts may be subject to proof that he or she is insurable. The Schedule of Insurance explains if and when we require proof. An employee won't be covered for any amount that requires such proof until he or she gives the proof to us and we approve that proof in writing.

An employee whose active full-time service ends before he or she meets any proof of insurability requirements that apply to him or her will still have to meet those requirements if he or she is later re-employed by you or an associated company.

GP-1-EC-90-3.0 P264.0066

Option A

The Waiting Period: Employees in an eligible class are eligible for disability income replacement insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0 P329.0003

Option A

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0 P180.0328

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A for Class 0001

WHEN EMPLOYEE COVERAGE STARTS

An employee must be actively at work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her. If an employee is not actively at work on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she returns to active full-time work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he or she was actively at work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

Whether an employee must pay all or part of the cost of employee coverage, he or she must elect to enroll and agree to make the required payments within 31 days of his or her eligibility date. If he or she does this on or before the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs his or her enrollment form. However, if he or she elects to enroll and agrees to make the required payments more than 31 days after his or her eligibility date, his or her coverage won't start until he or she sends us proof that he or she is insurable. Once we've approved it, his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

Any part of an employee's coverage which is subject to proof that he or she is insurable won't start unless he or she sends this proof to us, and we approve it in writing. Once we have approved it, that part of his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

GP-1-EC-90-6.0 P329.0091

Option A

Delayed Effective Date For Disability Coverage: With respect to this plan's disability insurance, if an employee is not actively at work on a full-time basis on the date his or her coverage is scheduled to start, due to sickness or injury, we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active full-time service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on he date the employee returns to active full-time service.

GP-1-DEF-97 P329.0048

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A for Class 0001

WHEN EMPLOYEE COVERAGE ENDS

When Employee Coverage Ends: An employee's long term disability insurance under this plan will end on the first of the following dates:

- the date an employee's active full-time service ends for any reason.
- the date an employee stops being an eligible employee under this plan.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs.
- the last day of the period for which required payments are made for the employee.

If an employee is disabled, as defined by this plan when his or her active full-time service ends, coverage remains inforce while such employee is continuously disabled, subject to all the terms of this plan.

GP-1-EC-90-8.0 P329.0089

Option A for Class 0001

When Active Service Ends: You may continue an employee's insurance under this plan after his or her active service with you ends only as follows:

- If an employee's active service ends because he or she is disabled you may continue his or her insurance subject to all of the terms of this plan.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his or her last day of active service, subject to any reductions that would have otherwise applied if he or she had remained an active employee.

GP-1-EC-90-7.0 P180.0265

Option A

Definitions

GP-1-EC-90-DEF-1 P180.0155

Option A

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3 P180.0311

Class 0001

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4 P180.0158

Option A

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-EC-90-DEF-6 P180.0160

Option A

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

GP-1-EC-90-DEF-7 P180.0161

Option A

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9 P180.0163

Option A

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10 P180.0164

Option A

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of a covered person's income if he or she becomes disabled due to sickness or injury.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below. However, decisions made by Guardian may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Provision of Coverage

Efficient management of the *plan* requires the joint efforts of the *plan sponsor,* Guardian, and each covered person. Each party has certain duties to bring about the effective administration of this *plan.*

Duties of the Plan Sponsor: The *plan sponsor's* primary duties under this *plan* are listed below.

(a) Give us prompt, written notice of any change in business of the *plan sponsor* and *employer.* This includes, but is not limited to: (i) the type of business; (ii) addition or deletion of an associated company; or (iii) financial status due to bankruptcy; merger; acquisition; or dissolution.

(b) Give us pertinent records for all covered persons. This includes, but is not limited to: (i) hire dates; (ii) eligibility dates; (iii) earnings; (iv) occupations; and (v) birth dates. Changes in earnings must be reported to us on a current basis, on this *plan's* Redetermination date. We use the earnings on record with us as of the Redetermination date immediately prior to a covered person's date of disability to determine amounts and limits under this *plan.* Updates to all other records must be reported as changes occur.

(c) In order to start case management, give us prompt notice of a covered person's *disability.* This notice should be given as soon as possible after the date of *injury* or start of *sickness.* The most effective time for such notice is when the covered person has not been able to perform *active work* for 30 days.

(d) In order to support case management, give us occupational data for all *disabled* covered persons. This includes, but is not limited to: (i) job descriptions and analyses; and (ii) environmental factors.

(e) Assist return to work efforts by providing: (i) worksite modifications; (ii) part-time work schedules; and or (iii) similar accommodations.

Duties of Covered Persons: A covered person's primary duties under this *plan* are listed below.

(a) Give notice of claim as soon as possible after the date of his or her *injury* or the start of his or her *sickness.* Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.

(b) Give a complete account of the details of his or her *sickness* or *injury.* This will include: (i) the cause of his or her *disability,* if known; (ii) a description of his or her *sickness* or the accident that caused his or her *injury;* and (iii) a list of all *doctors,* hospitals, or other facilities where he or she has been treated for the cause of his or her *disability.*

(c) Allow release of medical and/or income data needed to assess his or her claim.

(d) Give periodic medical updates as required by this *plan.*

(e) Take part in any medical, financial or vocational assessment as required by this *plan.*

(f) Apply for any income listed in "Other Income We Integrate With" that he or she may be entitled to

receive.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in his or her personal status. This includes: (i) change of address or phone number; (ii) changes in how his or her *disability* affects his or her daily living; and (iii) changes in his or her level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If he or she is working while *disabled,* promptly report to us the amount of *income earned during disability.*

(k) Give us proof of his or her earnings for the period prior to his or her *disability* and while he or she is *disabled.*

Our Duties: Our primary duties under this *plan* are listed below.

(a) Decide if a covered person is eligible for this coverage.

(b) Decide if a covered person meets the requirements for benefits to be paid by this *plan.*

(c) Decide what benefits are to be paid by this *plan.*

(d) Interpret how this *plan* is to be administered.

(e) Pay income replacement benefits to *disabled* covered persons who meet all *plan* requirements.

(f) Assess claims of all *disabled* covered persons to decide the merit of providing vocational rehabilitation and Social Security assistance services.

(g) Provide the *plan sponsor* with information on the Americans with Disabilities Act of 1992 and return to work assistance programs.

(h) Provide case management as described in this *plan.*

(i) Provide W-2 reporting and FICA match services.

Option A

Claim Provisions

Notice: A covered person must send us written notice of his or her intent to file a claim under this *plan* as described in "Accident and Health Claims Provisions." Notice must include:

(a) his or her full name; phone number; social security number, and group number;

(b) the date of his or her last day worked; the number of hours he or she worked; and his or her job title;

(c) his or her *employer* contact and phone number;

(d) a statement of the nature of his or her *disability;* and whether or not it is work-related;

(e) his or her *doctor's* name, address and phone number.

For details, the covered person can call Guardian at 1-800-538-4583.

Proof of Loss: When we receive a covered person's notice, we will provide him or her with a claim form for filing proof of loss. This form requires data from the *plan sponsor,* the covered person, and the *doctor(s)* treating the covered person for his or her *sickness* or *injury.* Proof of loss must be given to us within the time stated in "Accident and Health Claims Provisions." If the covered person does not receive a claim form within 15 days of the date he or she sent his or her notice, he or she should send us written proof of loss without waiting for the form.

This is a specimen copy of Master Group policy provisions which apply to this plan. Issuance of these materials of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

We require the items listed below as proof of loss:

(a) During the *elimination period* and the *own occupation* period, medical evidence in support of the limits on the covered person's ability to perform his or her *own occupation*, starting on the date he or she first became *disabled*. This proof is required from all *doctors* who have treated the covered person for the cause of his or her *disability*.

After the *own occupation* period, medical evidence in support of the limits on the covered person's ability to perform any *gainful work*.

(b) Proof that the covered person has applied for all other sources of income to which he or she may be entitled, that may affect his or her payment from this *plan*.

(c) Proof of receipt of other income that may affect the covered person's payment from this *plan*.

(d) The covered person's signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025

GP-1-LTD2K01-1.1 P380.0442

Option A

To Qualify for Payments

How Payments Start: To start getting payments from this *plan*, a covered person must meet all of the conditions listed below:

(a) He or she must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* for this *plan's elimination period.*

(b) He or she must be: (i) under a *doctor's regular care* for the cause of his or her *disability*, starting from the date he or she was first *disabled;* and (ii) receiving medical care appropriate to the cause of his or her *disability* and any other *sickness* or *injury* which exists during his or her *disability*.

(c) He or she must send us written documentation of: (i) medical evidence in support of the limits causing his or her *disability;* (ii) his or her monthly earnings prior to the start of his or her *disability;* and (iii) any *income earned during disability*.

We reserve the right to determine when a covered person meets the above conditions. Regular and appropriate care will be determined in accord with generally accepted medical standards. Our determination will be made based upon consideration of currently published guidelines from nationally recognized authorities. We consider the period of *disability* to start on the date the covered person becomes *disabled* while insured by this *plan.*

Proof of earnings may consist of: (1) copies of the covered person's U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver of Premium: Premiums for this insurance for a covered person are waived while he or she is entitled to receive a payment from this *plan*.

To Continue Receiving Payments: To continue to receive payments from this *plan*, a covered person must give us current proof of loss when we request it.

The covered person must give proof that satisfies us as to the items listed below:

(a) medical evidence in support of the limits causing his or her continued *disability;*

(b) continued *regular care* by a *doctor* that is appropriate for the cause of his or her *disability* and any other *sickness* or *injury* which exists during his or her *disability;*

(c) *income earned during disability;* and

(d) any income listed in "Other Income We Integrate With" that he or she is entitled to receive.

The covered person must also give us current signed authorizations for release of medical and financial data when we request it.

The covered person must permit such assessments and give us such items within 90 days of the date we make each such request. If he or she does not, we have the right to suspend or stop his or her payments under this *plan.*

Right to Request Medical, Financial or Vocational Assessment: We may ask a covered person to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If he or she does not take part in the assessment, we have the right to stop or suspend his or her payments under this *plan.*

GP-1-LTD01-2.0-NJ P380.1383

Option A

Payment of Benefits: We pay benefits to a covered person if he or she is legally competent. If he or she is not, we pay benefits to the legal representative of his or her estate.

We pay benefits once each month at the end of the period for which they are payable.

Benefits to which the covered person is entitled may remain unpaid at his or her death. Such benefits may be paid at our discretion to: (a) his or her estate; or (b) his or her spouse, parents, children, or brothers and sisters.

GP-1-LTD2K-2.1 P380.0018

Option A

When Benefits End

When Payments End: A covered person's benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date he or she is no longer *disabled.*

(b) The date he or she earns, or is able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(c) The date he or she is able to perform the major duties of his or her *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) After the *own occupation period,* the date he or she is able to perform the major duties of any *gainful work* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(e) The date he or she no longer resides in the United States.

(f) The date he or she dies.

(g) The end of the *maximum payment period.*

(h) The date he or she fails to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(i) The date he or she is no longer under the *regular care* of a *doctor.*

(j) The date payments end in accord with a *rehabilitation agreement.*

(k) The date he or she refuses to take part in a *rehabilitation program.*

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

Option A

Maximum Payment Period: The *maximum payment period* is the longest time that benefits are paid by this *plan* for a covered person's *disability*. It is determined by the table shown below.

But, it may be less than that shown due to the nature of the covered person's *disability*. See "Special Limitations."

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

GP-1-LTD2K-3.1 P380.0155

Option A

Special Limitations: We limit the *maximum payment period*, if the covered person is *disabled* due to: (a) a *mental or emotional condition;* or (b) drug or alcohol abuse.

The *maximum payment period* for all periods of *disability* due to *mental or emotional conditions* or drug or alcohol abuse is 24 months. This is a combined maximum for all such conditions and all periods of *disability*.

No benefits will be paid for *disability* due to a *mental or emotional condition* or drug or alcohol abuse if the covered person is not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, the covered person must meet all of the following conditions: (a) he or she must be *disabled* due to a *mental or emotional condition* or drug or alcohol abuse; (b) he or she must be an inpatient in a qualified institution because of his or her *disability;* and (c) he or she must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of his or her discharge; (ii) the end of this *plan's maximum payment period;* or (iii) the date his or her *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of the covered person's *disability.*

If This Plan Ends: This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for the covered person's class. If the covered person is *disabled* when this insurance ends, we will treat him or her as if his or her insurance did not end. But, his or her benefit will be based on all of the terms of this *plan.*

GP-1-LTD2K-3.2 P380.0030

Option A

To Determine a Covered Person's Benefit

A covered person's benefit is determined by the plan of benefits and his or her *insured earnings* in effect on the date his or her *disability* starts.

Any changes to this *plan* that take place while the covered person is *disabled* will not affect how we determine his or her benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability*.

Determining a Covered Person's Monthly Benefit: A covered person's *monthly benefit* is determined as shown below.

(a) Multiply his or her *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum monthly benefit,* that amount is his or her *gross monthly benefit.*

If the amount determined above is equal to or more than this *plan's maximum monthly benefit,* his or her *gross monthly benefit* is equal to the *maximum monthly benefit.*

(c) From his or her *gross monthly benefit,* subtract the amount of any income listed in "Other Income We Integrate With" that he or she receives or is entitled to receive. The result is his or her *monthly benefit.*

The amount of a covered person's *gross monthly benefit* may be limited if the *plan sponsor* has not updated the amount of the covered person's *insured earnings* to reflect his or her then current *insured earnings* on the most recent reporting date prior to the start of his or her *disability.*

See the "Redetermination" of this *plan* for details.

GP-1-LTD2K-4.0 P380.1334

Option A

Redetermination: This plan redetermines *insured earnings* for each covered person on the date a change in a covered person's *insured earnings* occurs. The *plan sponsor* must report updates to all covered persons' *insured earnings* as they occur. Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan.* As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan.* However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability*.

GP-1-LTD2K01-4.2 P380.0335

Option A

Other Income We Integrate With: A covered person may receive, or be entitled to receive, income shown in the list below. We will integrate his or her *gross monthly benefit* with such income to determine his or her *monthly benefit* from this *plan.*

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) the *employer.* This includes payments made by a group life insurance plan due to the covered person's *disability.* This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.

- Income from a sick leave or salary continuance plan of: (1) the *plan sponsor;* or (2) the *employer.* This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits for which: (i) the covered person is qualified; and (ii) his or her spouse and children are qualified due to the covered person's *disability;*

  (b) All unreduced retirement benefits due to the covered person's *disability* which: (i) the covered person receives; and (ii) his or her spouse and children receive due to the covered person's qualification; and

  (c) All reduced retirement benefits due to the covered person's *disability* paid to: (i) the covered person; and (ii) his or her spouse and children due to the covered person's receipt of such benefits.

  We will integrate the covered person's *gross monthly benefit* with such benefits to which his or her spouse and children are entitled due to the covered person's receipt of, or qualification for, disability benefits. We do this when the spouse or child resides with the covered person or when the covered person has a legal obligation to provide their financial support.
- *Retirement plan retirement benefits* funded for the covered person's benefit by: (1) the *plan sponsor;* or (2) the *employer.*
- *Retirement plan disability benefits* funded for the covered person's benefit by: (1) the *plan sponsor;* or (2) the *employer.*
- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; and (b) the Longshoreman's and Harbor Workers' Compensation Act.
- Payment from the covered person's *employer* as part of a termination agreement.

Option A

Lump Sum Payments of Other Income: Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine a covered person's *monthly benefit.* If no monthly rate is given, we pro-rate the lump sum over the number of months of the covered person's expected lifetime.

Cost of Living Freeze: A covered person may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce his or her *monthly benefit* by the amount of such increase.

Application for Other Income Required: A covered person must apply for any disability or retirement benefits we integrate with from the United States Social Security Act, the Railroad Retirement Act, or any other like U.S. or Canadian plan or act, which we feel, he or she may be entitled to receive. If such benefits are denied, we require the covered person to file a request for reconsideration of a denied disability claim. If such request is denied, we may require the covered person to request a hearing on the denial before an Administrative Law Judge. If we require the covered person to request such a hearing, we will pay for legal expenses and other costs incurred by him or her in proceeding with the hearing.

If the covered person requests us, we will integrate the *gross monthly benefit* with the estimated amount of the benefits shown above payable to him or her and his or her spouse and children on behalf of his or her *disability.*

We will also integrate the *gross monthly benefit* with the estimated amount of such benefits if the covered person fails to take the required action shown above within a reasonable period of time. But we do not do this if the covered person signs our reimbursement agreement. In this agreement the covered person promises:

(a) to apply for any such benefits with which we integrate; and (b) to repay any amount we overpaid due to an award of such benefits. If we do integrate the *gross monthly benefit* with such estimated amount and we receive written proof that he or she later takes the required action, we pay him or her the full amount of such integration in a lump sum including interest on that amount at the rate of interest, if any, the applicable plan or act pays on the amounts it owes; provided the covered person has not requested that we integrate the *gross monthly benefit* with the estimated amount of such benefits.

If we do estimate them, we will adjust the covered person's *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any requests for reconsideration or hearings we require. In the case of (b), if such adjustment shows we underpaid the covered person, we pay the full amount of the underpayment in a lump sum, including interest on that amount at the rate of interest, if any, the applicable plan or act pays on amounts it owes.

We will assist the covered person in applying for other income benefits.

GP-1-LTD2K-4.4-NJ P380.1354

Option A

Minimum Payment: The minimum monthly payment for *disability* under this *plan* is $100.00.

Partial Month Payment: A covered person may be *disabled* for only part of a month. In this case, we compute his or her payment as 1/30th of the benefit to which he or she would be entitled for the full month times the number of days he or she is *disabled.* Payment will not be made for more than 30 days in any month.

Overpayment Recovery: If we overpaid a covered person, he or she must repay us in full. We have the right to reduce his or her payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

GP-1-LTD2K-4.5 P380.0067

Option A

If a Covered Person Works While Disabled

Income Earned During Disability: This *plan* will not pay benefits for a covered person if he or she works during the *elimination period* and for one month after it. This does not include secondary employment that the covered person obtained prior to the start of *disability* and which he or she continues to perform at the same or lower level as prior to *disability.*

Subject to the other terms of this *plan,* if a covered person is working to his or *maximum capacity, income earned during disability* is treated as shown below. In all cases, the covered person's *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after the covered person returns to work, add his or her *gross monthly benefit* and his or her *income earned during disability.*
   (a) If the sum is not more than 100% of the covered person's *insured earnings,* we do not reduce his or her *monthly benefit* for that month.
   (b) If the sum is more than 100% of the covered person's *insured earnings* we reduce his or her *monthly benefit* for that month by the amount over 100% of his or her *insured earnings.*
2. For each month after 12 months of work while *disabled:*
   (a) If the covered person's *income earned during disability* is less than 20% of his or her *insured earnings,* we do not reduce his or her *monthly benefit* for that month.
   (b) If the covered person's *income earned during disability* is 20% or more of his or her *insured*

earnings, we reduce his or her *monthly benefit* for that month by 50% of his or her *income earned during disability.*

GP-1-LTD2K01-5.0 P380.1384

Option A

Part-Time Earnings Capacity: If a covered person is able to work *part-time* while *disabled,* but is not working to his or her *maximum capacity,* we adjust the *monthly benefit* as follows.

During the *own occupation* period, we reduce the covered person's *monthly benefit* by 50% of the income he or she would currently be able to earn, if working to his or her *maximum capacity,* in his or her *own occupation.* After the *own occupation* period, we reduce the covered person's *monthly benefit* by 50% of the income he or she would currently be able to earn, if working to his or her *maximum capacity,* in any *gainful occupation.*

Maximum Income Earned During Disability: This *plan* limits the amount of income a covered person may earn, or may be able to earn, and still be considered *disabled.*

If the covered person's *income earned during disability* is more than the limit shown below, payments from this *plan* will end. Payments from this *plan* will also end if he or she is able to earn more than the limit shown below.

(a) During the *own occupation* period, the limit is 80% of the covered person's *insured earnings.*

(b) After the *own occupation* period, the limit is 60% of the covered person's *insured earnings.*

In all cases, the covered person's *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

GP-1-LTD2K01-5.1 P380.0419

Option A

Indexing: If a covered person returns to work while *disabled,* we adjust his or her *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income the covered person may earn and still be considered *disabled.* This adjustment does not increase his or her *gross monthly benefit,* or any other benefit under this *plan.*

We make the first indexing adjustment after the covered person: (a) has returned to work; and (b) has received 12 monthly payments in a row from this *plan.*

To make the first adjustment, we multiply the covered person's *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of his or her last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

GP-1-LTD2K-5.2 P380.0076

Option A

Recurring Disability

A covered person's benefits from this *plan* will end because he or she ceases to be *disabled.* In this case, a later *disability* may be treated as a *recurring disability.* The terms listed below must be met:

(a) The covered person returns to *active work* right after his or her benefits end;

(b) The covered person's *disability* recurs less than six months after he or she was last entitled to benefits;

(c) The covered person's later *disability* is due to the same cause of, or a cause related to the cause of, his or her earlier *disability;*

(d) This *plan* does not end during the covered person's return to *active work;*

(e) The covered person does not become covered under any other similar group income replacement plan during the time he or she returns to *active work;*

(f) During the time the covered person returns to *active work,* he or she stays insured by this *plan* and premium payments are made on his or her behalf; and

(g) The covered person's benefits do not end because he or she has used up the *maximum payment period.*

Any changes in benefit or the *plan* which take place during the covered person's return to *active work,* will not apply to the *recurring disability.*

If the later *disability* is a *recurring disability,* the covered person will not need to complete a new *elimination period* before becoming entitled to benefits. His or her claim for *recurring disability* will be subject to the same terms of the *plan* as his or her earlier *disability.*

Option A

Services Available

Social Security Assistance: We may feel a covered person is qualified for Social Security disability benefits. If so, we may offer to help him or her apply for them. If such benefits are under review by Social Security, we may also offer to help him or her keep them.

We may offer to help:

(a) Fill out the covered person's application for such benefits, and any related forms;

(b) Find suitable legal counsel; and

(c) Give medical and vocational data needed to file the covered person's claim.

The covered person must apply for all income benefits for which he or she may be eligible, whether or not he or she uses our help. Using our help does not cancel the covered person's duties shown in the "Application for Other Income" section of this *plan.*

Rehabilitation and Case Management: Case management starts when we are notified of a covered person's *disability.*

We will review the covered person's *disability* to see if certain services are likely to help him or her return to *gainful work.* If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer the covered person a *rehabilitation program.* We have the right to suspend or end his or her *monthly benefit* if he or she does not accept it.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) the covered person; (2) us; and (3) the covered person's *employer,* if needed. The program may include, but is not limited to:

Specific provisions which apply to plans of insurance. The applicable of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

(a) vocational assessment of the covered person's work potential;

(b) coordination and transition planning with an employer for the covered person's return to work;

(c) consulting with the covered person's *doctor* on his or her return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining;

(f) child care expense aid; and

(g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to $2,500.00.

We have the right to determine which services are appropriate.

If the covered person accepts the *rehabilitation agreement,* we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date the covered person's benefits from this *plan* end;

(b) The date the covered person violates the terms of the *rehabilitation agreement;*

(c) The date the covered person ends the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

If the covered person ends a *rehabilitation program* without our consent, he or she must repay any enhanced benefits paid.

GP-1-LTD2K-8.0 P380.0092

Option A

Pre-Existing Conditions

Pre-Existing Conditions: A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the look back period, a covered person:

(a) receives advice or treatment from a *doctor;*

(b) takes prescribed drugs; or

(c) receives other medical care or treatment, including consultation with a *doctor.*

The covered person may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the six months before the latest of: (a) the effective date of the covered person's insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in the covered person's benefit election that increases the benefit payable by this *plan.*

A complication of pregnancy will not be considered a pre-existing condition if the complication arises on or after the date the covered person's insurance under this *plan* starts.

No benefits are payable for *disability* due to a pre-existing condition; unless the *disability* starts after the covered person completes at least one full day of *active work* after the date he or she is insured under this *plan* for 24 months in a row.

The covered person may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in his or her benefit election which increases the benefit payable by this *plan.* In this case, the covered person's benefit will be limited to the

amount that would have been payable had the change not taken place. This limit does not apply if his or her *disability* starts after the covered person completes at least one full day of *active work* after the change has been in force for 24 months in a row.

We do not cover any *disability* that starts before the covered person's insurance under this *plan.*

The term "complication of pregnancy" means:

(1) Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but will not include false labor, occasional spotting, doctor-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a diffcult pregnancy not constituting a nosologically distinct complication of pregnancy; and

(2) Nonelective caesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Option A

Prior Coverage Credit: If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to a covered person. This *plan* must start right after the old plan ends.

If the old plan had a pre-existing condition provision and the prior waiting period had not been satisfied in full, we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision or if it had one but it had been satisfied, we will pay benefits for disability due to a pre-existing condition. We do this if: (a) the disability begins while the covered person is insured by this *plan;* (b) the covered person was covered under the old plan when it ended; and (c) he or she is *actively-at-work* and enrolls for insurance on the effective date of this *plan.*

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) the covered person becomes *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because: (1) we credit time or (2) we waive the pre-existing condition provision, as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

Continuity of Coverage: A covered person may have been covered under another similar Guardian income replacement plan prior to his or her insurance under this *plan.* When this happens, this *plan's* pre-existing conditions provision will not apply to a condition for which we paid benefits for that covered person under the other Guardian plan. But: (a) the covered person's service with the *employer* must start right after the date his or her coverage under the other Guardian plan ended; and (b) the covered person must be insured under this *plan.*

Any other condition arising between the date the covered person's coverage under the other Guardian plan ends and the date his or her insurance under this *plan* starts is pre-existing. Except as stated above, we do not cover any disability which began before the covered person's insurance under this *plan* starts.

If the *plan sponsor* has included an eligibility waiting period in this *plan,* the covered person must still meet it before becoming insured under this *plan.*

Option A

Not Covered

Exclusions: This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) a covered person's taking part in a riot or civil disorder;

(d) a covered person's commission of, or attempt to commit a felony; or

(e) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability:*

(1) during which the covered person is confined to a facility as a result of his or her conviction of a crime;

(2) during which the covered person is not receiving *regular care by a doctor;*

(3) during which the covered person is not receiving medical care appropriate to the cause of his or her *disability* and any other *sickness* or *injury* which exists during his or her *disability;*

(4) which starts before the covered person is insured by this *plan;* or

(5) during which the covered person's loss of earnings is not solely due to his or her *disability.*

GP-1-LTD2K-10.0-NJ P380.1361

Option A

Definitions

Active Work, Actively-At-Work or Actively Working: A covered person is able to perform and is performing all of the regular duties of his or her work for his or her *employer,* on a full-time basis at: (a) one of his or her *employer's* usual places of business; (b) some place where his or her *employer's* business requires him or her to travel; or (c) any other place he or she and his or her *employer* have agreed on for his or her work.

GP-1-LTD2K-12.0 P380.0101

Option A

CPI-W: That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W,* we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

GP-1-LTD2K-12.2 P380.0103

Option A

Disability or Disabled: These terms mean a covered person has physical, mental or emotional limits caused by a current *sickness* or *injury.* And, due to these limits, he or she is not able to perform the major duties of his or her *own occupation* or any *gainful work* as shown below:

(1) During the *elimination period* and the *own occupation* period, he or she is not able to perform, on a full-time basis, the major duties of his or her *own occupation.*

(2) After the end of the *own occupation* period, he or she is not able to perform, on a full-time basis, the major duties of any *gainful work.*

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

The covered person is not *disabled* if he or she performs any work for wage or profit during the *elimination period* and for one month after it. This does not include secondary employment that the covered person obtained prior to the start of *disability* and which he or she continues to perform at the same or lower level as prior to *disability.*

The covered person is not *disabled* if he or she earns, or is able to earn, more than this *plan's* maximum allowed *income earned during disability.*

The covered person may be required, on average, to work more than 40 hours per week. In this case, he or she is not *disabled* if he or she is able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability.*

GP-1-LTD2K-12.3 P380.1364

Option A

Doctor: Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize a covered person, or his or her spouse, child, parent, sibling, or business associate, as a *doctor* with respect to his or her claim for this *plan's* benefits.

Elimination Period: The period of time a covered person must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which the covered person returns to *active work* will not count toward the *elimination period.* The *elimination period* will be extended by one day for each day of *active work.* If he or she becomes eligible under any other similar group income replacement plan while he or she is at *active work,* he or she will not be entitled to benefits from this *plan.*

If the covered person returns to *active work* for more than 45 days during the *elimination period,* he or she must start a new *elimination period.*

Employer: The business entity that employs a covered person and is: (a) the *plan sponsor;* or (b) associated with the *plan sponsor.*

GP-1-LTD2K-12.10 P380.0114

Option A

Gainful Occupation or Gainful Work: Work for which a covered person is, or may become, qualified by: (a) training; (b) education; or (c) experience. When a covered person is able to perform such work on a full-time basis, he or she can be expected to earn at least 60% of his or her indexed *insured earnings,* within 12 months of returning to work.

Gross Monthly Benefit: This *plan's monthly benefit* before it is reduced by other income and earnings.

Income Earned During Disability: The monthly income a covered person earns from working while *disabled.* It includes any income he or she earns while *disabled* but which is returned to his or her *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If the covered person had secondary employment prior to *disability, income earned during disability* will only include increases in earnings from this employment due to an increase in the number of hours worked.

Injury: A bodily *injury* due to an accident that occurs, independent of all other causes, while a covered person is insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

GP-1-LTD01-12.11-NJ P380.1398

Option A

Insured Earnings: Only a covered person's earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of the covered person's *insured earnings* on record with us as of the Redetermination date immediately prior to the start of his or her disability. See the "Redetermination" section of this *plan.*

Insured earnings includes the covered person's contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means his or her rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the *plan sponsor.* If he or she is paid hourly, we calculate monthly earnings based on actual hours worked or billed in the two months before the start of his or her *disability.* We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.

Option A

Maximum Capacity: During the *own occupation* period, the fullest extent of work a covered person is able to do in his or her *own occupation.* After the *own occupation period,* the fullest extent of work a covered person is able to do in any *gainful occupation.* We decide the fullest extent of work a covered person is able to do based on objective data provided by: (a) his or her treating doctor; (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to the covered person's *disability.*

Maximum Payment Period: The longest time that benefits are paid by this *plan.*

Mental or Emotional Conditions: This term includes, but is not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder.

Monthly Benefit: This plan's *gross monthly benefit* reduced by other income with which we integrate. See "Other Income We Integrate With." If a covered person is working while *disabled,* his or her *monthly benefit* will be further reduced based on the amount of his or her *income earned during disability.* See the "If A Covered Person Works While Disabled" provision of this *plan* for how this is done.

Option A

Own Occupation: A covered person's occupation as done in the general labor market in the national economy. To determine the duties and requirements of his or her *own occupation,* we use: (a) the job description provided by the *plan sponsor;* and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.

Part-Time: The ability to work and earn between 40% and 80% of *insured earnings* during the *own occupation* period and between 40% and 60% of *insured earnings* after the *own occupation* period.

Plan Sponsor: The *employer,* association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability: A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care: A person is being treated by, or in consultation with, a *doctor* at a frequency that is consistent with his or her condition and in accord with generally accepted medical standards. The requirement for *regular care* does not apply if he or she has reached his or her maximum point of recovery yet is still disabled under the terms of this *plan*.

GP-1-LTD01-12.14-NJ P380.1407

Option A

Rehabilitation Agreement: A formal agreement between; (a) a covered person; (b) us; and (c) the covered person's *employer,* if needed. It outlines the *rehabilitation program* in which the covered person agrees to take part.

Rehabilitation Program: A program of work or job-related training for a covered person that we approve in writing. Its aim is to restore his or her wage earning abilities.

Retirement Plan: A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for a covered person's benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans: (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans. *Retirement Plan* **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness: An illness or disease. Pregnancy is treated as a *sickness* under this *plan*.

We, Us, and Guardian: The Guardian Life Insurance Company of America.

GP-1-LTD2K-12.15 P380.0138

Option A

ELIGIBILITY FOR MAJOR MEDICAL COVERAGE

P449.0005

Option A

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0 P180.0168

Option A

Enrollment Requirement: If an employee must pay all or part of the cost of employee coverage, we won't insure him or her until he or she enrolls for the coverage and agrees to make the required payments. If the employee is a late enrollee, as defined in this coverage, the employee is subject to this coverage's pre-existing conditions limitation for late enrollees.

A late enrollee is an employee who fails to enroll for major medical coverage: (a) within 30 days of his or her hire for full-time service with you; or (b) during a special enrollment period, as described below. However, if an eligibility waiting period applies to an employee, the employee will be considered a late enrollee if he or she fails to enroll within 30 days of the end of the waiting period.

However, if the employee elects to enroll in this coverage after he or she previously waived major medical coverage under this plan because he or she was covered under another group plan, and, upon his or her notification by us of this requirement, he or she stated this in writing at time of such waiver, we will not consider the employee to be a late enrollee, if his or her coverage under the other plan ends due to:

(a) the exhaustion of a COBRA continuation of coverage;

(b) the death of a spouse;

(c) the legal separation or divorce from a spouse;

(d) the end of employment or a reduction in work hours; or

(e) the end of employer contributions toward the other plan, or the end of the other plan.

But the employee must enroll in this coverage within 30 days of the date his or her coverage under the other plan ends.

Also, an employee will not be considered a late enrollee if he or she enrolls during a special enrollment period. A special enrollment period means a 30 day period which begins on the later of: (a) the date dependent major medical coverage is made available under this plan; and (b) the date an employee acquires an eligible dependent through marriage, birth, adoption or placement for adoption. An employee, and his or her eligible spouse, may enroll in this coverage at the same time he or she enrolls a new eligible dependent.

GP-1-EC-90-2.0 P449.0112

Option A

The Waiting Period: Employees in an eligible class are eligible for major medical insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0 P449.0004

Option A

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0 P180.0328

Option A

When Employee Coverage Starts

An employee must be actively at work, unless he or she is disabled, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her. If an employee is not actively at work, unless he or she is disabled, on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he or she was actively at work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

Whether an employee must pay all or part of the cost of employee coverage, he or she must elect to enroll and agree to make required payments within 30 days of his or her eligibility date. If he or she does this on or before the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs the enrollment form.

GP-1-EC-90-6.0 P449.0117

Option A for Class 0001

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the date an employee's active full-time service ends for any reason other than disability. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
- the date an employee stops being an eligible employee under this plan.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs.
- the last day of the period for which required payments are made for the employee.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. And an employee may have the right to replace certain group benefits with converted policies. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0 P449.0103

Option A for Class 0001

When Active Service Ends: You may continue an employee's major medical expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0 P449.0002

Option A

Definitions

GP-1-EC-90-DEF-1 P180.0155

Option A

Eligible Dependent is defined in the provision entitled "Dependent Coverage".

GP-1-EC-90-DEF-2 P180.0156

Option A

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3 P180.0311

Class 0001

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4 P180.0158

Option A

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-EC-90-DEF-6 P180.0160

Option A

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9 P180.0163

Option A

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10 P180.0164

Option A

Dependent Coverage

GP-1-DEP-90-1.0 P200.0305

Option A

Eligible Dependents For Dependent Major Medical Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her unmarried dependent children who are under age 23; and (c) his or her unmarried dependent children, from age 23 until their 25th birthday, who are enrolled as full-time students at accredited schools.

GP-1-DEP-90-2.0 P200.0508

Option A

Adopted Children and Step-Children: An employee's "unmarried dependent children" include his or her legally adopted children and, if they depend on him or her for most of their support and maintenance, his or her step-children. We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

The "Pre-Existing Conditions" provision of the major medical portion of this plan, if any, does not apply to an adopted child, if the child: (a) is adopted or placed for adoption prior to his or her 18th birthday; and (b) becomes covered by this plan within 30 days of such placement.

Dependents Not Eligible: We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

GP-1-DEP-90-3.1 P200.0491

Option A

Handicapped Children: An employee may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached the age limit; (b) he or she became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on the employee for most of his or her support and maintenance.

But, for the child to stay eligible, the employee must send us written proof that the child is handicapped and depends on the employee for most of his or her support and maintenance. The employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when the employee's does.

GP-1-DEP-90-4.0 P489.0030

Option A for Class 0001

When Dependent Coverage Starts: In order for an employee's dependent coverage to start he or she must already be insured for employee major medical coverage, or enroll for employee and dependent major medical coverage at the same time. The date an employee's dependent coverage starts depends on when he or she elects to enroll his or her initial dependents and agrees to make any required payments.

If the employee does this on or before his or her eligibility date, each initial dependent's coverage is scheduled to start on the later of the employee's eligibility date and the date he or she becomes insured for employee coverage.

If the employee does this within or after the enrollment period, each initial dependent's coverage is scheduled to start on the later of the date the employee signs the enrollment form and the date the employee becomes insured for employee coverage.

However, if the employee does this after the enrollment period, each initial dependent is considered a late enrollee, and is subject to this coverage's pre-existing conditions limitation for late enrollees.

Once an employee has coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents, and agree to make any additional required payments. The newly acquired dependent's major medical coverage will start on the date the employee signs the enrollment form, if the employee notifies us within 30 days of the date the dependent is acquired. If the employee fails to notify us within 30 days of the date the dependent is acquired, the dependent is considered a late enrollee, and is subject to this coverage's pre-existing conditions limitation for late enrollees.

A late enrollee is a dependent who the employee fails to enroll for major medical coverage: (a) during the enrollment period if the dependent is an initial dependent; (b) within 30 days of the date a dependent becomes an eligible dependent, if the dependent is not an initial dependent; or (c) during a special enrollment period, as described below.

However, if the employee elects to enroll a dependent in this coverage after he or she previously waived major medical coverage under this plan for the dependent, because the dependent was covered under another group plan, and, upon his or her notification by us of this requirement, the employee stated this in writing at the time of the waiver, we will not consider the dependent to be a late enrollee, if the dependent's coverage under the other plan ends due to:

(a) the exhaustion of a COBRA continuation of coverage;

(b) a death, divorce or legal separation;

(c) the end of employment or reduction of work hours; or

(d) the end of employer contributions toward the other plan, or the end of the othe plan.

But the employee must enroll the dependent in this coverage within 30 days of the date his or her coverage under the other plan ends. And the dependent must still be an eligible dependent.

Also, a dependent will not be considered a late enrollee if he or she is enrolled during a special enrollment period. A special enrollment period means a 30 day period which begins on the later of: (a) the date dependent major medical coverage is made available under this plan; and (b) the date an employee acquires an eligible dependent through marriage, birth, adoption or placement for adoption. An employee may enroll an eligible spouse who was previously not enrolled at this time.

And a dependent will not be considered to be a late enrollee if he or she is enrolled due to a court order which mandates that the employee provide this major medical coverage for such dependent.

Option A

Newborn Children: We cover an employee's newborn child for dependent benefits, from the moment of birth if: (a) the employee is already covered for dependent child coverage when the child is born; or (b) the employee enrolls the child for dependent coverage within 31 days of the child's birth and agrees to make any required premium payments within 31 days of the date the child is born. If the employee fails to do this, when enrolled, the child will be considered a late enrollee, and is subject to this coverage's pre-existing conditions limitations for late enrollees. The child's coverage starts on the date the enrollment form is signed.

GP-1-DEP-90-8.0 P449.0135

Option A

When Dependent Coverage Ends: Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry. And we'll also automatically cover a newborn child born to an employee's spouse within six months of the employee's death. But any such newborn child's coverage will end six months from the date the employee died. There is no cost for this coverage. If a surviving dependent elects to continue his or her dependent benefits under this plan's "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of an employee's dependents when the employee stops being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee's class.

If an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And they may have the right to replace certain group benefits with converted policies.

GP-1-DEP-90-9.1 P449.0060

Option A

Definitions

GP-1-DEP-90-DEF-1 P200.0210

Option A

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2 P200.0211

Option A

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

GP-1-DEP-90-DEF-3 P200.0212

Option A

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4 P200.0213

Option A

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8 P200.0217

Option A

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9 P200.0218

Option A

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-DEP-90-DEF-11 P200.0220

Option A

Proof or **Proof of Insurability** means an application for insurance showing that a person is insurable.

GP-1-DEP-90-DEF-12 P200.0221

Option A

We, Us, Our and **Guardian** means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14 P200.0223

Option A

You and **Your** means the employer who purchased this plan.

GP-1-DEP-90-DEF-15 P200.0224

Option A

NEW JERSEY REQUIRED DISCLOSURE FOR MANAGED CARE PLANS

Providers in our network have agreed to be paid each time they treat the covered person ("Fee for Service").

If the covered person wants more information about how our providers are paid, he or she can call or write to:

Guardian
Bethlehem Regional Office
Customer Response Unit
P.O. Box 26055
Lehigh Valley, PA 18002
1-888-278-4542

The laws of the State of New Jersey at: N.J.S.A 45:9-22.4 et seq. mandate that a doctor, chiropractor or podiatrist who is permitted to refer his or her patients to other health care providers in which he or she has a significant financial interest must tell his or her patients, at the time of referral, of any significant financial interest he or she may have in those health care providers or facilities. If the covered person wants more information about this, he or she may contact his or her doctor, chiropractor or podiatrist. If the covered person believes that he or she is not receiving the information to which he or she is entitled, he or she may contact: Division of Consumer Affairs New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

The general public may contact the Department for the results of: (a) independent consumer satisfaction surveys; and (b) analyses of quality outcomes for health care services provided under managed care plans in New Jersey.

A covered person can ask for and receive the following information: (a) if a provider is board certified; (b) whether a network provider is accepting new patients; or how he or she can get this information on his or her own at no cost; and (c) the standards set for waiting times for appointments for routine and emergency care.

GP-1-MCP-DISC-NJ P453.5725

Option A

MAJOR MEDICAL EXPENSE INSURANCE

This major medical insurance will pay many of the medical expenses incurred by an employee and his dependents.

GP-1-R3-1.0 P450.1158

Option A

Preferred Provider Organization Features

Private Healthcare Systems; This Plan's Preferred Provider Organization: This plan encourages a covered person to use services provided by members of Private Healthcare Systems (PHCS), a Preferred Provider Organization (PPO). A PPO is a network of health care providers located in the covered person's geographical area. In addition to an identification card, the covered person will periodically be given up-to-date lists of PHCS preferred providers.

Use of the network is strictly voluntary. But we generally pay a higher level of benefit for most covered services and supplies furnished to a covered person by PHCS. Conversely, we generally pay a lower level of benefits when covered services and supplies are not furnished by PHCS (even if a PHCS doctor orders the service and supplies). Of course, a covered person is always free to be treated by any doctor or facility. And he or she is free to change doctors or facilities at any time.

A covered person may use any PHCS provider. He or she just presents his or her PHCS i.d. card to the PHCS doctor or facility furnishing covered services or supplies. Most PHCS doctors and facilities will prepare any necessary claim forms for him or her, and submit the forms to us. The covered person will receive an explanation of any insurance payments made by this plan.

Hold Harmless Clause: The covered person will not be held financially liable for payments to health care providers for any sums owed for covered services if we fail to pay benefits for the covered services for any reason, other than the co-payments, coinsurance or deductibles being required by this plan, or the services not being medically necessary.

Emergency Care: If a covered person requires emergency care, as defined below, we'll pay benefits for covered charges for such care at the co-payment rate for services of a preferred provider, even if the emergency care is received from a non-preferred provider. What we pay is based on all of the other terms of this plan.

Utilization Review Features: This plan also has utilization review features. Under these features, PHCS reviews hospital admissions and surgery performed outside of a doctor's office for us. These features must be complied with whenever a covered person: (a) enters a hospital; or (b) is advised to enter a hospital or to have surgery performed outside of a doctor's office. If a covered person does not comply with these utilization review features, he or she will not be eligible for full plan benefits. See the "Utilization Review Features" section for details.

What we pay is subject to all the terms of this plan. Read this plan carefully and keep it available when consulting a doctor.

See the schedule of insurance for specific benefit levels, payment rates and payment limits.

If a covered person has any questions after reading this plan, he or she should call The Guardian Group Claim Office at the number shown on his or her i.d. card.

GP-1-PPO-NJ-94 P453.3225

Option A

Utilization Review Features

Important Notice: This section must be complied with when a covered person: (a) enters a hospital; or (b) is advised to enter a hospital or have surgery performed outside of a doctor's office. If the doctor who: (a) is admitting the covered person to the hospital; or (b) is advising the covered person to have the surgery is a PHCS doctor, the doctor will assume the responsibilty for complying with this section. And the covered person will be held harmless for any non-compliance penalties. In all other cases, if a covered person does not comply with this plan's utilization review features, he or she will not be eligible for full plan benefits.

Compliance with this plan's utilization review features does not guarantee what we'll pay for covered charges. What we pay is based on: (a) the covered charges actually incurred; (b) the covered person being eligible for coverage under this plan at the time the covered charges are incurred; and (c) the deductible and co-payment provisions and all of the other terms of this plan.

Definitions: "Hospital admission" means admission of a covered person to a hospital as an inpatient for medically necessary care or treatment of a sickness or injury.

By "emergency care" we mean covered services that are provided by any health care provider, which are needed immediately because of an injury or sudden illness and the time required to reach a preferred provider would have meant serious deterioration of, or risk of permanent damage to, the covered person's health. These services are considered to be emergency care as long as transfer of the covered person to a preferred provider is precluded because of risk to the covered person's health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the medical condition.

By "covered professional charges for surgery" we mean covered charges that are made by a doctor for performing surgery. Any surgical charge which is not a covered charge under the terms of this plan is not payable under this plan.

"Regular working day" means Monday through Friday from 8:30 a.m. to 5:00 p.m., Eastern Time, not including legal holidays.

Option A

Emergency Room Charges: If a covered person requires treatment in a hospital emergency room as a result of an emergency, we'll pay benefits for the covered charges listed below:

- ambulance charges for transporting the person to the hospital emergency room for treatment;
- doctors' charges for emergency room care;
- hospital charges for the emergency room visit. This includes hospital charges for x-rays, lab work and other similar services; and
- hospital charges and doctors' charges for admissions from the emergency room.

These covered charges will be paid at the co-payment rate for services of an in-network provider. This is true even if the emergency care is received from an out-of-network provider. What we pay is based on all the other terms of this plan.

As used herein, an "emergency" means the sudden onset of a condition that manifests itself by acute symptoms of sufficient severity or severe pain so that a prudent layperson who has an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the covered person; or (b) in the case of a pregnant woman: (i) the health of the woman; or (ii) her unborn child, in serious jeopardy; (c) serious impairment to bodily function; or (d) serious dysfunction of any bodily organ or part.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

Option A

Required Pre-Hospital Review

Important Notice: If a covered person using a non-PHCS doctor does not comply with these hospital stay review features, he or she will not be eligible for full plan benefits.

Notice of Hospital Admission Required: We require notice of all hospital admissions. The times and the manner in which the notice must be given are described below. When a covered person does not comply with the requirements of this section, we reduce what we'd otherwise pay for covered charges for hospital services, as a penalty.

Pre-Hospital Review: All non-emergency hospital admissions must be reviewed by PHCS before they occur.

The covered person or his or her doctor must notify PHCS and request a pre-hospital review. PHCS must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a covered person or her doctor must notify PHCS and request a pre-hospital review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

When PHCS receives the notice and request, they evaluate: (a) the medical necessity of the hospital admission; (b) the anticipated length of stay; and (c) the appropriateness of health care alternatives, like home health care or other outpatient care.

PHCS notifies the covered person and the covered person's doctor, by phone, of the outcome of the review. And they confirm the outcome of the review in writing to the covered person and the covered person's doctor.

If PHCS authorizes a hospital admission, the authorization is valid for: (a) the specified hospital; (b) the named attending doctor; and (c) the authorized length of stay.

The authorization becomes invalid and the covered person's admission must be reviewed by PHCS again if: (a) he or she enters a facility other than the specified facility; (b) he or she changes attending doctors; or (c) more than 60 days elaspe between the time he or she obtains authorization and the time he or she enters the hospital, except in the case of a maternity admission.

If PHCS determines that the proposed hospital admission is not medically necessary, we pay no benefits for the admission.

Pre-Surgical Review: If the covered person is being admitted to a hospital for surgery, the "Required Pre-Surgical Review" section must be complied with. See "Required Pre-Surgical Review" for details.

Emergency Admissions: PHCS must be notified of all emergency admissions by phone. This must be done by the covered person or his or her doctor no later than the end of the next regular working day or as soon as possible after the admission occurs.

When PHCS is notified by phone, they require the following information: (a) the covered person's name, social security number and date of birth; (b) the covered person's group plan number; (c) the reason for the admission; (d) the name and location of the hospital; (e) when the admission occurred; and (f) the name of the covered person's doctor.

Continued Stay Review: The covered person, or his or her doctor, must request a continued stay review for any emergency admission. This must be done at the time PHCS is notified of such admission.

The covered person, or his or her doctor, must also initiate a continued stay review whenever it is medically necessary to change the authorized length of a hospital stay. This must be done before the end of the previously authorized length of stay.

PHCS also has the right to initiate a continued stay review of any hospital admission. And PHCS may contact the covered person's doctor or hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates: (a) the medical necessity of the hospital admission; (b) the anticipated length of stay; and (c) the appropriateness of health care alternatives. In all other cases, the continued stay review evaluates: (a) the medical necessity of extending the authorized length of stay; and (b) the appropriateness of health care alternatives.

PHCS notifies the covered person and the covered person's doctor, by phone, of the outcome of the review. And PHCS confirms the outcome of the review in writing to the covered person and the covered person's doctor. The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance: In the case of each non-emergency hospital admission, as a penalty for non-compliance, we reduce what we would have paid for covered hospital charges by $500.00, if: (a) the covered person, or his or her doctor does not request a required pre-hospital review as soon as possible before the hospital admission is scheduled to occur; or (b) PHCS' authorization becomes invalid and the covered person or his or her doctor does not obtain a new one.

In the case of each emergency admission, as a penalty for non-compliance, we reduce what we would have paid for covered hospital charges by $500.00 if: (a) PHCS is not notified of the admission at the times and in the manner described above; or (b) the covered person does not request a continued stay review. The penalty applies to covered hospital charges incurred after the end of the applicable time limit allowed for giving notice.

For each hospital admission, if a covered person stays in the hospital longer than PHCS authorizes, we reduce what we would have paid for covered hospital charges incurred after the end of the authorized length of stay by $500.00, as a penalty for non-compliance.

We pay no benefits for a hospital admission, or any part thereof, which is not medically necessary.

Penalties can't be used to meet this plan's: (a) cash deductibles; or (b) limits on out-of-pocket expenses.

GP-1-PPO-HUR-NJ-94 P453.3217

Option A

Required Pre-Surgical Review

Important Notice: If a covered person using a non-PHCS doctor, does not comply with these pre-surgical review features, he or she will not be eligible for full plan benefits.

When A Review Must be Done: We require a covered person to get a pre-surgical review for any non-emergency procedure performed outside of a doctor's office. When a covered person does not comply with the requirements of this section, we reduce what we'd otherwise pay for covered professional charges for surgery, as a penalty.

The covered person or his or her doctor must request a pre-surgical review from PHCS. PHCS must receive the request at least 24 hours before the surgery is scheduled to occur. If the surgery is being done in a hospital, on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When PHCS receives the request, they evaluate the medical necessity of the surgery. PHCS notifies the covered person and the covered person's doctor, by phone, of the outcome of the review. And PHCS confirms the outcome of the review in writing to the covered person and the covered person's doctor. If the review confirms the medical necessity of the proposed surgery, we pay benefits for the surgery, subject to all the terms of this plan. If the review does not confirm the medical necessity of the proposed surgery, we pay no benefits for the surgery and related charges. See the "Appeals Process" section of this plan.

Pre-Hospital Review: If the proposed surgery is to be done on an inpatient basis, the "Required Pre-Hospital Review" section must be complied with. See the "Required Pre-Hospital Review" section for details.

Penalties for Non-Compliance: For each surgery, as a penalty for non-compliance, we reduce what we would have paid for covered professional charges related to surgery by $500.00, if: (a) the covered person or his or her doctor does not request a required pre-surgical review; or (b) PHCS is not given at least 24 hours

to review and evaluate the proposed surgery; or (c) as part of an appeal, the covered person does not get a second opinion upon PHCS request, or if he or she does get a second opinion, it is from a doctor who is not on PHCS' list of specialists.

Please note, however, that whether or not a covered person complies with these pre-surgical review requirements, we pay no benefits for surgery which is not medically necessary.

Penalties can't be used to meet this plan's: (a) deductibles; or (b) limits on out-of-pocket expenses.

Option A

APPEALS PROCESS

Definitions: As used in this Section:

"Certification" means a decision by PHCS that an admission, continued stay or surgical procedure has been reviewed and, based on the information provided, is: (a) medically necessary; (b) appropriate; and (c) effective.

"Continued stay review" means a review conducted for a continued hospital stay, including an emergency admission.

"Department" means the New Jersey Department of Health and Senior Services.

"Discharge planning" means the formal process to set up the care that a covered person will receive after discharge from a facility.

"Emergency" means a medical condition with acute symptoms that are severe enough to lead a prudent lay person, with an average knowledge of health and medicine, to reasonably expect that not getting immediate treatment would result in: (a) placing the health of the person (for a pregnant woman, the woman or her unborn child) in grave danger; or (b) serious impairment of: (i) bodily functions; or (ii) a body part or organ. These symptoms include, but are not limited to: (a) severe pain; or (b) psychiatric and/or symptoms of drug abuse. For a pregnant woman in labor, an emergency exists if: (a) there is not enough time to safely transfer her to another hospital before delivery; or (b) the transfer may pose a threat to her health and safety or that of her unborn child.

"Independent Health Care Appeals Program (IHCAP)" means the external appeals process used to appeal a decision that denies, reduces or ends services or payments that are otherwise covered under this plan.

"Independent utilization review organization (IURO)" means an organization that contracts with the Department to provide independent reviews under the external appeals process in regard to a service being medically necessary or appropriate.

"Non-certification" means a decision by PHCS that an admission, continued stay or surgical procedure has been reviewed and, based on the information provided, is not: (a) medically necessary; (b) appropriate; and (c) effective.

"Preauthorization of Ambulatory Care Procedures" means a review to preauthorize health services provided in an outpatient setting.

"Provider" means any doctor or health care professional, hospital, facility or other person who is licensed or authorized to provide health care or other services in the state or jurisdiction in which the services are furnished.

"Retrospective review" means a review of a service or supply after it has been provided in regard to whether it was medically necessary or appropriate.

"Utilization management (UM)" means a system with specific guidelines to review whether health care services, given or proposed to be given, were or are: (a) medically necessary; (b) appropriate; and (c) efficient, in order to determine if they should or will be reimbursed, covered, paid for or otherwise provided under this plan. The system may include: (a) preadmission certification; (b) preauthorization of ambulatory care procedures; (c) continued stay review; (d) discharge planning; and (e) retrospective review. It does not include a review of requests for a clarification of coverage or payment amounts.

Utilization Management (UM) Appeals: If a covered person or a provider, acting with consent on his or her behalf, does not agree with a UM decision, he or she, or that provider, has the right to appeal:

- a non-certification; or
- a matter arising from a Guardian action or inaction, unrelated to non-certification.

Specimen copy of Master Group Policy provisions which will be issued if this plan is approved. The appeals of these provisions are part of a master group policy delivered in the State of Rhode Island to the Citizens Savings Bank and Citizens Trust Company (Trustee) as Policyholder.

An appeal for non-certification is an appeal to PHCS for its UM decision in regard to: (a) an admission; (b) continued stay; or (c) surgical procedure that denies, ends or limits services or payments.

An appeal unrelated to non-certification is an appeal to Guardian for its UM decision that denies, ends or limits services or payments for health care services.

The criteria used to make a UM decision for the specific treatment or service under review are available upon request to a covered person or a provider, if involved.

Levels of Appeals: This plan has: (a) an internal appeals process; (b) an external appeals process; and (c) an expedited appeals process.

At each appeal level, all available information required for a review must be provided, including any requested second surgical opinion. If the covered person or a provider will not release the required information, a certification or coverage for a procedure or service may be denied. Any added information which: (a) relates to the case; and (b) impacts an adverse decision, will be considered in the review.

Directions for each appeal level are shown below.

Internal Appeals Process: There are two stages for internal appeals. Stage one is oral and informal; stage two is written and formal. Before filing a stage two formal appeal, the stage one informal appeal must be exhausted.

Stage One Informal Appeals: To start the stage one informal appeal of the initial UM decision, the covered person or a provider, acting with consent on his or her behalf, must call the appropriate toll-free telephone number shown below to ask for a review. The covered person or provider, if involved, will be able to speak to the medical director or the medical director's designee who made the decision in order to discuss his or her objection to it.

For a PHCS non-certification appeal, the telephone number is: 1-800-227-6921

For an appeal to Guardian unrelated to non-certification, the telephone number is: 1-888-278-4542

The appeal must be concluded within:

- 72 hours of its receipt in the case of an expedited appeal for an emergency, including any inpatient confinement (See Expedited Appeal and Emergency Care Services below); or
- 5 business days of its receipt for all other appeals.

The covered person and the provider, if involved, will receive notice of the outcome of the appeal in writing. If the denial of the initial UM decision is upheld, the notice will include: (a) the reasons the denial is being upheld; (b) the right to request the clinical rationale used to make the decision; and (c) the right to make a stage two formal appeal and to whom it must be sent.

Stage Two Formal Appeals: If a covered person or a provider, acting with consent on his or her behalf, is not satisfied with the outcome of the stage one informal appeal, he or she or the provider may request a stage two formal appeal.

To start the stage two formal appeal, the request must be submitted in writing to the appropriate address shown below. Upon receipt of the appeal, it will be given to a panel made up of doctors and/or other providers who were not involved in the UM decision being reviewed.

Option A

The panel will have access to: (a) consulting providers who are trained or practicing in the same specialty as would typically manage the case being reviewed; and (b) other licensed providers, if all parties agree. These providers must not have been involved in the UM decision at issue. And, the covered person or provider, acting with consent on his or her behalf, may request that the consulting providers be included in the panel.

For a PHCS non-certification appeal, the address is:

Medical Director
Private Health Care Systems, Inc.
Utilization Review Department
110 Winter Street
Waltham, MA 02451-1227

For an appeal to Guardian unrelated to non-certification, the address is:

Guardian
Bethlehem Regional Office
Quality Assurance Department
P.O. Box 26010
Lehigh Valley, PA 18002-6010

The stage two formal appeal will be acknowledged in writing within 10 business days after its receipt.

The appeal must be concluded within:

- 72 hours of its receipt in the case of an expedited appeal for an emergency, including any inpatient confinement (See Expedited Appeal and Emergency Care Services below); or
- 20 business days of its receipt for all other appeals.

  The review period may be extended for 20 more business days when there is reasonable cause for a delay that is shown to be beyond the control of the party conducting the review. The Department must receive and be satisfied with a written progress report that explains the reasons for the delay. And, the covered person and provider, if involved, must be notified of such delay within the original 20 business day review period.

If the stage two formal appeal results in a denial, written notice of the denial will be sent to the covered person and/or the provider, if involved. The notice will explain the decision and the reasons for it. It will advise the covered person and/or provider that he or she has the right to file an external appeal. The notice will also include: (a) specific instructions for filing an external appeal; and (b) the application form required to initiate such an appeal.

Expedited Appeals: When an emergency exists and/or emergency care services are required, a covered person or a provider, acting with consent on his or her behalf, may ask for an expedited review under either a stage one or stage two internal appeal.

As indicated above in regard to the time frames for concluding stage one and stage two appeals, an expedited appeal must be resolved within 72 hours of receipt of the appeal.

Written notice of the outcome of the expedited review will be sent to the covered person and the provider, if involved. The notice sent for the expedited review will contain the same information and directions described above for a stage one or stage two internal appeal, whichever is appropriate.

Emergency Care Services: These are services we cover that treat or stabilize an emergency condition that seriously jeopardizes the covered person's: (a) life or health; or (b) ability to regain maximum function. Such services will include: (a) treatment at any designated level 1 or 2 trauma center as medically necessary until the patient: (i) is medically stable; (ii) no longer needs critical care; and (iii) can be safely sent to another facility; and (b) a medical screening when the covered person arrives at a hospital to determine if an emergency exists.

Emergency Telephone Response System: The "911" emergency response number may be called whenever a covered person has a potentially life threatening condition. The "911" number will appear on the covered person's medical plan I.D. card.

External Appeals Process: These are appeals conducted through an independent program (IHCAP) by an independent utilization review organization (IURO).

If the covered person or a provider, acting with consent on his or her behalf, is not satisfied with the outcome of the internal review process, he or she or the provider has the right to an external appeal.

All internal appeal rights must be exhausted before an external appeal can be initiated. But, this does not apply if one or more of the required time frames for the internal appeals process was not met.

Guardian will pay the cost of the external review.

To start an external appeal, the covered person or a provider, acting with consent on his or her behalf, must file the application form, including the executed release, required by the Department The form must be filed within 60 days from: (a) the date the final internal appeal decision was received; or (b) the last date that an internal appeal was filed if the covered person or provider believes any of the required internal appeals time frames were not met.

The covered person or provider, if involved, must certify on the application form either: (a) that all internal appeal rights have been exhausted; or (b) that one or more of the time frames set forth for internal appeals was not met; and, that he or she did not hinder the internal appeal decision process by not providing all of the relevant information requested.

The appeal form must be completed and mailed to:

Department of Health and Senior Services
Office of Managed Care
Division of Health Care Systems Analysis
P.O. Box 360
Trenton, New Jersey 08625-0360

A filing fee of $ 25.00 must be sent with the form. The filing fee shall be paid by check or money order to the order of the "New Jersey Department of Health and Senior Services."

But, the covered person can ask that the fee be waived due to financial hardship. To do this, he or she must demonstrate the need for a fee reduction and submit this information with the appeal form. The Department will decide if the covered person will pay a reduced fee.

IURO Procedures: Upon receipt of the application form, the executed release and the fee, the assigned IURO conducts a preliminary review to be sure: (a) that the review is a legitimate one; and (b) that it has all the information it needs for a full review.

Once this preliminary review is completed, the IURO will notify the covered person and/or provider in writing whether or not it accepts the application form for a full review. If the IURO does not accept the form, it will explain the reasons for not accepting it.

If the application form is accepted, the IURO will conduct a full review to decide if services or benefit payments for covered medically necessary treatment or supplies were inappropriately denied. In its full review, the IURO considers: (a) medical records; (b) consulting doctor reports; (c) any other documents the parties submit; (d) accepted practice guidelines of the Federal government, and professional medical societies, boards and associations; and (e) clinical protocols used by the parties who made the internal appeals decisions.

The IURO must complete its full review and issue its decision in writing no later than 30 business days after receipt of the application form.

The review period may be extended if there are reasons for a delay beyond the IURO's control. Written notice of the delay must be sent to the covered person, his or her provider, Guardian and the Department within the original 30 day review period. The notice will contain the reasons for the delay, the review status and expected date of completion. The IURO must render its decision no later than 90 days after receipt of a completed application form.

But, if the appeal is for an emergency case, the IURO must complete the review within 48 hours after receipt of the appeal.

The IURO will send its decision in writing to the covered person, the provider, if involved, Guardian and the Department. In the decision, the IURO will specify those appropriate, medically necessary covered services that the covered person should receive. The IURO decision is binding on Guardian.

Option A

Action on IURO Decision: If all or part of the IURO decision favors the covered person, Guardian will promptly provide coverage for those denied, reduced or terminated health care services found by the IURO to be medically necessary covered services.

If the IURO decision is in favor of Guardian and the covered person does not agree with the decision, he or she may seek those desired health care services outside of this plan, at his or her own expense.

Complaint System: Guardian's Compliance area is the business unit with the overall responsibility for resolving the complaints of covered persons in regard to: (a) contracts or policies; (b) choice and accessibility of network providers; and (c) network adequacy.

The system established by this business unit to respond to complaints:

- records and documents the status of all complaints and keeps these records for three years;
- has a service representative to assist the covered person with the complaint process, upon request;
- has specified response times which can not exceed 30 days from the receipt of the complaint; and
- has written procedures for processing and resolving complaints.

Complaint Process: To start the complaint process, the covered person or provider, acting with consent on his or her behalf, may call or write to:

Guardian Compliance
7 Hanover Square
Mail Station H23N
New York, NY 10004-2616
Telephone Number: (212) 598-1384

When the unit receives the written or oral complaint, the date is noted.

After an initial analysis, the complaint is forwarded to the appropriate department for review and response.

The person assigned to process the complaint will send a written acknowledgment of its receipt.

The complaint will be investigated and a decision reached in regard to how it will be settled.

A written response explaining how the complaint was resolved will be sent to the covered person and/or provider, if involved. The reasons for the decision must be included if it was not in favor of the person making the complaint.

The covered person and/or provider, if involved, will be advised that he or she may contact the Department or the Department of Banking and Insurance if he or she is not satisfied with the resolution of the complaint

Guardian will not end coverage or penalize a covered person or provider for exercising his or her right to file a complaint.